STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 24, 25, 26, 27, 28, 31, and February 4, 2011 Facility number: 000051 Provider number: 155121 AIM number: 100275490 Survey Team: Cheryl Groth, RN, TC Megan Wyant, RN Brenda Nunan, RN Census bed type: SNF: 20 SNF/NF: 128 Total: 148 Census payor type: Medicare: 42 Medicaid: 85 Other: 21 Total: 148 Sample: 24 Supplemental sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 11, 2011 by Bev Faulkner, RN	F 000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. **This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation on March 4, 2011.** **This facility also requests that an informal dispute resolution for deletion or reduction of F315.** RECEIVED FEB 28 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157	**F157 Physician Notification** It is the practice of this provider to immediately inform the resident,	

app 3/14/11 3 Hour BR/BN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dean E Ramsey | TITLE: Executive Director | (X6) DATE: 2/28/2011

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the physician was notified related to a deep tissue injury and abnormal blood sugars. This deficient practice effected 2 of 24 residents reviewed for physician notification in a sample of 24. (Resident # 88 and	F 157	consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #88 physician was notified of deep tissue injury and treatment was verified and placed on treatment sheet. • Resident #11 blood sugars are monitored per physicians order with physician notification per parameters. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 #11) Findings include: 1. During an observation on 1/25/11 at 10:40 a.m., with LPN #11 and the Director of Nursing (DoN) Resident #88's left foot was observed to have a 0.5 cm (centimeter) x 0.9 cm (centimeter) x less than 0.1 cm deep tissue injury present to the outer heel. Resident #88's record was reviewed on 1/25/11 at 3:25 p.m. Resident #88's diagnoses included, but were not limited to, malnutrition and right extremity above the knee amputation. Documentation was lacking to indicate the physician had been made aware of the deep tissue injury which was identified on 1/25/11 at 10:40 a.m. An interview with LPN #6 and LPN #11 on 1/26/11 at 10:30 a.m., indicated the MD should have been notified of the deep tissue injury on Resident #88's heel immediately following the observation on 1/25/11 at 10:40 a.m. The LPN indicated she did not notify the MD. An interview with the DoN on 1/26/11 at 10:35 a.m., indicated the MD should have been notified of the deep tissue injury when the area was identified on 1/25/11. She confirmed the notification had not been made to the physician by the LPN. 2. The clinical record for Resident # 11 was reviewed on 2/4/11 at 9:55 A.M. Diagnoses for the resident included, but were not limited to, insulin dependent diabetes mellitus.	F 157	• Residents who experience a change of condition have the potential to be affected by the alleged deficient practice. • Nursing staff was re-educated on change of condition and physician notification by Staff Development Coordinator /Designee by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Diabetic resident's blood sugars are monitored and tracked on the flow sheet daily by the licensed nurse. • Nurse Managers review the blood sugar flow sheet daily for any change of condition. • The Nurse Manager on Call will be notified of acute resident changes. • The Nurse Manager on Call will notify the Director of Nursing Services and/or the Executive Director of any change of conditions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 A current care plan for the resident, initially dated 6/9/10, indicated the resident was at risk for adverse effects of hyperglycemia and hypoglycemia related to the use of glucose lowering medication and a diagnosis of diabetes mellitus. Interventions related to this concern included, but were not limited to, monitor blood sugars as ordered and document abnormal findings and notify the physician. The physician's order summary for 2/11 indicated the resident had the following physician's orders: Check blood sugar twice daily If blood sugar is less than 60 and the resident is responsive give 4 ounces of juice/milk, recheck in 15 minutes if still less than 60 call the physician Review of the "Capillary Blood Glucose Monitoring Tool" for 1/11 indicated the resident had a blood sugar of 57 on 1/21/11 at 4:00 P.M. There was no documentation on the form to indicate the physician was notified of the residents low blood sugar level or that the resident's blood sugar was rechecked in 15 minutes. There was no documentation in the clinical record to indicate the physician was notified of the resident's decreased blood sugar levels on 1/21/11. During an interview with the Director of Nursing on 2/4/11 at 12:40 P.M., she indicated there was no documentation to indicate the physician was notified of the resident's decreased blood sugar on 1/21/11. She indicated the nursing staff should have notified the resident's physician at	F 157	• Director of Nursing/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • A "Change of Condition" CQI tool will be utilized twice a week for 4 weeks and then weekly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 that time. 3. A current facility policy, revised 3/10, provided by the Director of Nursing on 1/26/11 at 11:30 A.M., titled "Resident Change of Condition" indicated, "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs. ... Acute Medical Change a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician. ... d. All nursing action//intervention will be documented in the medical record as soon as possible after resident needs have been met. ... Routine Medical Change a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly. Routine changes are a minor change in physician and mental behavior, abnormal laboratory and x-ray results that are not life threatening. ... g. The licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the resident's condition has stabilized...."	F 157		
F 164 SS=D	3.1-5(a)(2) 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	F 164	**F164 Personal Privacy/confidentiality of records** It is the practice of this provider to provide each resident with the right to personal privacy and confidentiality of his or her personal and clinical records.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 5 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure privacy was maintained during treatments provided by facility staff. This deficient practice effected 1 of 24 residents reviewed for privacy in a sample of 24; and 2 of 2 residents in a supplemental sample of 7. (Residents #115, # 63, and 88). Findings include: 1. During blood glucose checks and insulin medication administration observations on	F 164	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Residents #63, #88 & #115 receive resident care as provided to ensure personal privacy. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents who reside in the facility have the potential to be affected by the alleged deficient practice. • Staff was re-educated on resident rights by Staff Development Coordinator/Designee by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 6 1/24/11 at 4:10 p.m., with LPN #15 and the Director of Nursing (DoN) the following was observed: 1a. During a blood glucose check and subsequent insulin administration on 1/24/11 at 4:10 p.m., LPN#15 did not make any attempt to close the door to Resident # 115's room or pull the privacy curtain. The LPN asked the resident to lift her shirt. The insulin was administered in the resident's abdomen. Resident # 115's daughter was in the room at the time of the insulin administration. There were staff and residents in the hallway going past the resident's room during the treatments. 1b. During a blood glucose check and subsequent insulin administration on 1/24/11 at 4:22 p.m., LPN #15 did not make any attempt to close the door to Resident # 63's room or pull the privacy curtain. The LPN asked the resident to lift her shirt. The insulin was administered in the resident's abdomen. There were staff and resident's in the hallway going past the residents room during the treatments. During an interview with LPN #15 immediately following this observation, she indicated she should have shut the door to the resident's room or pulled the privacy curtain when she did the blood sugar checks and insulin administrations. During an interview with the DoN immediately following the observation, she indicated the LPN should have shut the residents door or pulled the residents curtains in an effort to provide privacy during the both blood sugar checks and insulin administrations.	F 164	• The Interdisciplinary Team will round daily to identify privacy issues. • The licensed nurse will observe for privacy issues during rounds on their assigned shift. • The Executive Director or Social Service Worker will attend Resident Council, with the permission of the Council President, monthly for three months to identify and address privacy issues. • Director of Nursing/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • A "QIS resident interview" CQI tool will be completed twice a week for 4 weeks and then weekly thereafter. • The CQI committee will review the data gathered and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 7 2. During an observation on 1/25/11 at 10:40 a.m., with LPN # 11 and the Director of Nursing (DoN) of a dressing change on Resident #88's foot, the LPN failed to close the door or pull the privacy curtain in the resident's room. The LPN removed the old dressing, cleansed, and assessed the resident's foot with the door to the room open and no privacy curtain pulled. The door to the room was not closed until the DoN left and re-entered the room with supplies needed to re-dress the resident's foot. There were residents and staff observed in the hallway during the dressing change. During an interview with LPN #11 immediately following the observation, she indicated she should have shut the door. During an interview with the DoN immediately following the observation, she indicated the LPN should have shut the door or pulled the privacy curtain closed. 3. A current facility policy, revised 1/06, provided by the Executive Director on 1/25/11 at 8:50 A.M., titled "Resident Rights" indicated, "...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care.... The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment...personal care...A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...."	F 164	if threshold is not achieved an action plan may be developed. • Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 8 3.1-3(o)	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure resident's dignity was maintained related to the use of clothing protectors to wipe resident's mouths, excessive facial hair for female residents, and prolonged exposure of the buttocks during perineal care. This deficient practice effected 7 of 24 residents reviewed for dignity in a sample of 24. (Resident #41, # 148, #27, #70, #90 # 135 and #134) Findings include: 1. During the meal observation in the cafe on the second floor on 1/24/11 at 12:15 p.m., the following was observed: 1a. Resident #41 was being fed by QMA #17. QMA #17 was observed using the clothing protector 2 times to wipe the resident's mouth. There was a napkin on the table next to the resident's plate of food. 1b. Resident #148 was being fed by QMA # 16. QMA #16 was observed using the clothing protector 4 times to wipe the resident's mouth. There was a napkin on the table next to the	F 241	**F241 Dignity and Respect of individuality** It is the practice of this provider to assure that the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Residents #27, #41, #70, #90, #134, #135 and #148 receive resident care as provided to ensure dignity during activities of daily living and administration of treatments. • Staff were re-educated by Staff Development Coordinator/ designee on the importance of using napkins and/or washcloths for pre-/post-cleansing at meals; closing doors and curtains prior to completing care on residents and covering residents while	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 10 in the 2 nd floor dining room. The resident was noted to have excessive facial hair on her chin. During an interview with the DoN on 1/27/11 at 10:50 A.M., she indicated every female in the building with facial hair should be taken care of. She indicated staff should honor the resident's preference for the method of hair removal. She indicated a resident's facial hair should be taken care of everyday of the week. 3. During an observation on 01/24/2011 at 2:00 p.m., the bare buttocks of Resident # 135 was visible by persons passing the open doorway of the resident's room. A staff person was in the hallway at the time of the observation. During an interview on 01/24/2011 at 2:00 p.m., CNA (Certified Nursing Assistant) # 4 indicated the resident's door was not closed and the privacy curtain was not pulled since he was only in the room to pick up a pillow from the floor. He indicated he should have covered the resident's exposed buttocks immediately when entering the room. 4. During an observation on 01/25/2011 at 8:50 a.m., LPN # 1 completed a dressing change to Resident # 134's wound on her coccyx (commonly referred to as the tailbone). The dressing change was observed by RN # 3. Upon completion of the wound care, LPN # 1 gathered the soiled dressing supplies and linens and removed them from the bedside before pulling up the resident's undergarment and slacks. During an interview with LPN # 1 and RN # 3 on 01/25/2011 at 9:15 a.m., each nurse indicated the resident's clothing should have been pulled up	F 241	• The Executive Director or Social Service Worker will attend Resident Council, with the permission of the Council President, monthly for three months to identify and address dignity issues. • Director of Nursing/designee is responsible to ensure compliance with facility procedure. • Each dining area will have washcloths available for pre and/or post cleansing for meals. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • A "Dignity" CQI tool will be completed twice a week for 4 weeks and then weekly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility policy and procedure may result in employee re-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 11 before the soiled supplies were removed from the bedside. 5. A current facility policy, revised 1/06, provided by the Executive Director on 1/25/11 at 8:50 A.M., titled "Resident Rights" indicated, "...All staff members recognize the rights of resident at all times and residents assume their responsibilities to enable personal dignity, well being, and proper deliver of care....A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...." 3.1-3(t)	F 241	education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	
F 252 3S=B	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident's environment was maintained in a clean and sanitary manner related to a stove top with debris and a soiled chair in the dining room. This deficient practice had the potential to affect all resident's who ate in the second floor dining room and 27 of 27 residents who resided in the memory care unit. (Second floor dining room and Auguste's Cottage)	F 252	**F252** **Safe/Clean/Comfortable/Homelike environment** It is the practice of this facility to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • No residents identified by the alleged deficient practice. **How will you identify other residents having the potential to be**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 12 Findings include: 1. During observation of the lunch meal on 1/24/11 beginning at 12:39 P.M., the following was observed: A resident was transferred from a stationary dining chair to her wheelchair at 12:55 P.M. At that time, it was noted that the resident's pants were soiled with urine, and the dining chair was soiled with urine. At that time, staff did not remove the chair from the table and the dining room area. At the time of the observation, other residents were seated at the table near the soiled chair. At 1:10 P.M., the Director of Nursing was informed by the surveyor that the chair in the dining room was soiled. At that time, the Director of Nursing confirmed the chair was soiled and she removed the chair. She indicated the nursing staff should have pulled the chair out for the housekeeper to clean. She further indicated she would ensure the chair was cleaned. A current facility policy related to the cleaning of the facility dining rooms, dated 10/02, provided by the Executive Director on 1/25/11 at 8:50 A.M., titled "Restaurant Cleaning" indicated, "...The Restaurant must always be clean, pleasant and aesthetically attractive. ... Restaurant chairs should be free from stains or food remnants....Assess chairs, seats and arms, for food bits and stickiness. Wipe with damp rag, if necessary...." 2. During the environmental tour, with the Maintenance Supervisor and the Housekeeping Supervisor, on 1/26/11 at 1:25 P.M., the following was observed:	F 252	**affected by the same deficient practice and what corrective action will be taken?** • Residents who reside in the facility have the potential to be effected by the alleged deficient practice. • Housekeeping staff will be re-educated by the Housekeeping Supervisor/ designee on cleaning procedure of soiled restaurant chairs and appliances by March 4, 2011. • Activities staff will be re-educated by the Housekeeping Supervisor/ designee on cleaning of appliances by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • After meals restaurant chairs will be cleaned per procedure. • Nursing and Activities staff was re-educated on infection control, including removing restaurant chairs if soiled by the Staff Development	

Coordinator/designee by March 4, 2011.

- Nurse Managers will round daily to observe for a clean environment.
- Housekeeping Supervisor is responsible to ensure compliance with procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- Infection Control Unit Environmental Rounds tool will be utilized twice a week for one month and weekly times 3 months.
- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 13 On the Auguste's Cottage unit, a locked memory care unit, the stove in the kitchenette area had debris under the burners. On three of the 4 burners, there was debris noted in the drip pans. At the time of the observation, an unidentified nursing aide indicated she had started her shift recently, and she was not sure if the stove had been used for an activity that day. An interview with the Housekeeping Supervisor immediately following the observation indicated the stove top should be cleaned. 3.1-19(f)(5)	F 252		
F 272 TS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	**F272 Comprehensive Assessments** It is the practice of this provider to assess residents initially and periodically with a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #26, #96, #116, #125 and #134 have comprehensive, accurate assessments that reflect residents' current status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 14 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to ensure assessments were accurate, completed, and updated related to upper respiratory and urinary tract infections requiring antibiotic use, PICC (peripherally inserted central catheter) line removal, dialysis access site, abdominal, bowel and bladder, pressure ulcer risk, dietary, and AIMS assessments. This deficient practice effected 5 of 24 residents reviewed for accurate, completed, and updated assessments in a sample of 24 residents. (Residents #26, #96, #116, #125, and #134) Findings include: 1a. Resident #26's record was reviewed on 1/28/11 at 10:00 a.m. Diagnoses for Resident #26 included, but was note limited to, anxiety, hypothyroidism, recurrent UTI (urinary tract infection), asthma, GERD (gastroesophageal reflux disease), dysphagia (difficulty swallowing), and a history of CHF (congestive heart failure). The nurses notes indicated the following: "...12/23/10 1 p (p.m.), Res (resident) c/o sore	F 272	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents who reside in the facility have the potential to be affected by the alleged deficient practice. • Licensed nurses were re-educated on accurate assessments with residents who utilize PIC lines, antibiotic usage, dialysis sites, by the Staff Development Coordinator/designee by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Residents who utilize antibiotics are put on the 24-hour report sheet as well as on the hot charting list. • Physician orders and reasons for antibiotic usage will be reviewed each morning (Monday thought Friday) by the IDT Team, to ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 15 throat, cough, has nasal congestion lungs clear notified MD await reply...." Documentation was lacking related to vitals having been obtained. "...12/23/10 4:45 pm, N.O. (new order) Z-pak (antibiotic) po (orally) ii (two) initial dose, then i (one) tab (tablet) x 4 days/URI (upper respiratory infection)...." Documentation was lacking to indicate a respiratory assessment and vitals had been completed. "...12/24/10 12 am, Res resting, quietly in bed. T 97.0. 0 (no) c/o sore throat. 0 SOB(shortness of breath), cough noted at this time. 0 c/o pain/discomfort...." Documentation was lacking to indicate any assessment related to respiratory status or the use of antibiotic had been documented in the nurses notes from 12/24/10 at 12:00 a.m., through 12/25/10 at 9:45 a.m. "12/25/10 9:45 am...T (temperature) 98.6, p (pulse) 68, r (respirations) 18, b/p (blood pressure)111/68, SpO2 (oxygen saturation) 96% on room air. ATB (antibiotic) continues S (without) s/s (signs/symptoms) adverse effects...." Documentation was lacking to indicate what the lungs sounded like, if there was any cough or sore throat. Documentation was lacking in the nurses' notes related to a respiratory assessment having been completed from 12/25/10 at 9:45 a.m., through 12/27/10 when the resident completed the antibiotic to treat the upper respiratory infection. During an interview with LPN #10 on 12/31/11 at 8:25 a.m., she indicated assessments should be	F 272	correct charting is being completed. Nurse Manager on call will review these on Saturday and Sunday. • Residents on dialysis and / or those with PIC lines will have assessments flow sheet that is completed by licensed nurse. • Director of Nursing/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • A "Interim Care Plan / Hot Charting Assessment" CQI tool will be utilized twice a week for 1 month then weekly times 2 months then quarterly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility procedure may result in employee re-education and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 16 done and documented on every shift. She indicated the assessment should include temperature, lung sounds, cough, shortness of breath. She indicated the assessment should include any documentation related to the respiratory status of the resident. She indicated the assessments in the resident's chart were lacking information and had not been completed every shift. During an interview with LPN#6 on 12/31/11 at 8:35 a.m., she indicated respiratory assessments of the resident should have been done every shift. She indicated the assessment should include information related to auscultation of the lungs, vitals, sputum production, cough, shortness of breath. She indicated the assessments were not done appropriately. During an interview with the Director of Nursing on 12/31/11 at 8:40 a.m., she indicated staff should have been assessing Resident #26's respiratory status every shift. She indicated the assessments should include lung sounds, temperature, cough, shortness of breath, need for oxygen, and pain. She indicated she had concerns with the lack of assessments from nursing staff. 1b. A physician's order, dated 12/27/10, indicated "...straight cath (urinary catheterization) for UA/ C+S (urinary catheterization/cultures and sensitivity) 12/28/10...." A care plan attached to the physician's orders indicated "...problem increased (arrow up) agitation, anxiety + confusion...interventions...str (straight) cath/ UA/C+S...." The nurses' notes indicated the following:	F 272	disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 17	F 272		

"...12/28/10 9:30 p.m., UA/C+S obtained. Awaiting lab pick up...0 (no) c/o (complaints of) pain or discomfort...." Documentation was lacking related to fluid consumption or urinary assessment had been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion.

Documentation was lacking in the nurses notes' from 12/28/10 through 12/30/10 at 2:45 p.m., related to fluid consumption or urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion.

"...12/30/10 2:45 p.m., UA results returned from M.D. Awaiting C+S + colony count. Will fax MD when available...." Documentation was lacking to indicate fluid consumption or urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion.

"...1/1/11 2pm...ATB for UTI continues. VSS (vital signs) 128/74, 60, 18, 98.2...." Documentation was lacking to indicate the physician had prescribed antibiotics to treat the resident's UTI at this time. Documentation was lacking related to fluid consumption or urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion.

"...1/2/11 11 a...Res is confused most of the time... Res had U/A + lab work done the 12/28/10. MD notified + said not to do anything + we are still awaiting C+S + colony count....."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 18 Documentation was lacking to indicate fluid consumption was being addressed or a urinary assessment had been completed. Documentation was lacking in the nurses' notes related to fluid status or a urinary assessment having been completed from 1/2/11 at 11:00 a.m., through 1/4/11 at 9:00 a.m. A physician's order, dated 1/3/11, indicated "...Septra DS (antibiotic) i (one) po (orally) BID (two times per day) x (times) 5 days for UTI...." The nurses' notes indicated the following: "...1/4/11 9a (a.m.)...on ATB (antibiotic) therapy for UTI. T (temperature) 97.1. 0 (no) AVR (adverse reactions) noted...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...1/4/11 7:25 p.m...ATB continues s (without) s/s (signs/symptoms) adverse effects..." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...1/5/11 11 a Continues on ATB-UTI. 0 AVR noted. No c/o pain or discomfort...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 19 "...1/5/11 8:30 pm Res continues on ATB/UTI. Temp 98.2...0 c/o pain or discomfort...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...1/6/11 2 am Res continues on ATB therapy for UTI. T-98.0. 0 AVR noted.) c/o pain or discomfort...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. Documentation was lacking related to fluid status or a urinary assessment having been completed from 1/6/11 at 2:00 a.m., until 1/7/11 at 11: 00 a.m. "...1/7/11 11 am Continues on ATB-UTI. 0 AVR noted. T 97.4 0 c/o pain or discomfort...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. During an interview with LPN #10 on 12/31/11 at 8:25 a.m., she indicated assessments for a resident with a UTI included urinary output, color of urine, frequency of urine, urgency with urination, pain with urination, temperature of the resident, and fluids should be encouraged. She indicated all this information should be documented on every shift. She indicated documentation of urinary assessments and	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 20 documentation related to fluids were lacking for Resident #26. During an interview with LPN #6 on 12/31/11 at 8:35 a.m., she indicated assessments for a resident with a UTI included vital signs, urinary output, color of urine, frequency of urine, odor of urine, dysuria, pain with urination, and fluids should be encouraged. She indicated all this information should be documented on every shift. She indicated documentation of urinary assessments and documentation related to fluids were lacking for Resident #26. During an interview with the DoN on 12/31/11 at 8:40 a.m., she indicated assessments for a resident with a UTI included every shift documentation of burning upon urination, odor of urine, color of urine, vitals of the resident, response to antibiotics, pain upon urination, and acceptance of fluids. The DoN indicated the staff were not documenting assessments of the resident every shift. She indicated she was not seeing documentation of acceptance of increased fluids. She indicated she had concerns with staff assessment and documentation related to the UTI for Resident # 26. 2. The clinical record for Resident # 96 was reviewed on 1/25/11 at 10:15 A.M. A physician's order for the resident, dated 10/2/10, indicated the resident was to have a peripherally inserted central catheter (PICC) removed due to non-use. The care plan update on the bottom of the physician's order, indicated the nursing staff were to assess the PICC site, measure the length of the catheter, and ensure the tip of the catheter was intact.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 21 A nursing note, dated 10/4/10 at 10:00 A.M., indicated, "...Notified DON (Director of Nursing) of resident's PICC line needed to be removed...." There was no documentation in the clinical record to indicate the resident's PICC line was discontinued or an assessment was completed at the time of the removal of the PICC line. During an interview with the Director of Nursing on 2/4/11 at 9:45 A.M., she indicated there was no documentation of an assessment related to the removal of the PICC line. During an interview with the Director of Nursing on 2/4/11 at 10:30 A.M., she indicated she was the nurse who removed the PICC line, and she did not document an assessment of the resident at that time. 3. The clinical record for Resident # 125 was reviewed on 1/27/11 at 12:05 P.M. Diagnoses for the resident included, but were not limited to, history of renal failure. A nursing note, dated 11/26/10 at 9:30 P.M., indicated, "... res (resident) to start dialysis tomorrow..." A nursing note, dated 12/5/10 at 7:00 P.M., indicated, "... Res returned to facility... Res has an IJ (internal jugular) port on R (right) upper chest...." Review of the physician's order summary for 1/11 indicated the resident had a dialysis access site in the right upper chest. The order's indicated staff were to assess the resident's access site for a bruit and thrill every shift.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 22 Review of the Medication Administration Record (MAR) for 12/10 and 1/11 indicated the staff were to assess the resident's access site for a bruit and thrill every shift. This assessment was initialed as completed during 12/10 and 1/11. During an interview with RN # 3 on 1/27/11 at 4:20 P.M., she indicated the resident had a port to the right side of his chest. She indicated you would check the site to ensure there was no bleeding. She indicated she would also look for signs of infection. During an observation of the site and interview with the Assistant Director of Nursing on 1/27/11 at 4:22 P.M., she indicated the site on the resident's chest looked like an AV shunt, but could not confirm this because of the dressing. She indicated staff would assess for a bruit and thrill and signs of infection. During an interview with the Director of Nursing on 1/28/11 at 11:20 A.M., she indicated the resident's dialysis access site is an internal jugular line. She indicated staff would not be able to assess the site for a bruit and thrill. She indicated the site should be assessed for pain and bleeding, but not a bruit and thrill. She indicated she understood it was a concern that staff had documented an incorrect assessment. 4. The clinical record for Resident # 116 was reviewed on 1/28/11 at 11:40 A.M. Diagnoses for the resident included, but were not limited to, gastroesophageal reflux disease, hypertension, and hypothyroidism. Review of a quarterly minimum data set	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 23	F 272		

assessment, dated 10/15/10, indicated the resident was incontinent of bowel.

A current care plan for the resident, initially dated 1/15/11, indicated the resident was at risk for constipation related to decreased mobility and medications. Interventions related to this concern indicated staff were to monitor the resident's bowel function and administer medications as ordered. The care plan also indicated an abdominal assessment would include bowel sounds, abdominal distension, hyper or hypoactive bowel sounds, and abdominal pain or tenderness.

Review of the physician's order summary for 2/11, indicated the resident had the following orders for bowel management:

Milk of Magnesia (a laxative) 30 milliliters by mouth once daily as needed for constipation

Bisacodyl suppository 10 milligrams once daily as needed for constipation.

Review of the "ADL (activities of daily living) Record" for 12/10, indicated the resident did not have a bowel movement from 12/12/10 through 12/15/10.

Review of the Medication Administration Record (MAR) indicated the resident did not receive any bowel management interventions during that time period.

There was no documentation in the clinical record to indicate the nursing staff completed an abdominal assessment of the resident during the time she did not have a bowel movement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 24 During an interview with the Director of Nursing on 1/28/11 at 4:11 P.M., she indicated the nursing staff should have completed an abdominal assessment at the time the resident did not have a bowel movement. She indicated she had looked at the clinical record and the 24 hour report sheets, and she was not able to find a documented assessment. She indicated the facility did not have a bowel management policy. 5. The clinical record for Resident # 134 was reviewed on 01/26/2011 at 2:50 p.m. Diagnoses included, but were not limited to, renal (kidney) failure, severe protein malnutrition, venous stasis (slow blood flow through veins) ulcer, right lower extremity, deep vein thrombosis (blood clot), hypertension (high blood pressure), and depression. A dietary progress note, dated 01/07/2011, indicated, "Res (resident) currently in hospital...Jan (January) 2011 wt (weight) 154 # (pounds); Dec (December) 2010 157 #; Oct (October) 2010 183 #. Sig (Significant) wt. loss...Will re-assess upon return....." A diet communication form, dated 01/11/11, indicated "Return from Hospital...." Documentation was lacking to indicate that the dietitian assessed the resident upon return from the hospital. During an interview on 01/27/2011 at 9:00 a.m., the DoN (Director of Nursing) indicated the dietitian should have assessed the resident upon return from the hospital.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 25 During an interview on 01/27/2011 at 9:30 a.m., the dietitian indicated she missed doing the assessment and that it should have been completed when the resident returned to the facility. A facility policy titled "Nutrition Risk Assessment," dated 12/00, was provided by the dietitian. The policy indicated, "...Nutrition Risk Assessment will be completed...With (SIC) each significant change in condition...."	F 272		
F 276 SS=D	3.1-31(a) 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were updated at least quarterly for 1 of 24 residents reviewed for quarterly assessments in a sample of 24 residents (Resident # 148). Findings include: The clinical record for Resident # 148 was reviewed on 01/27/2011 at 10:45 a.m. Diagnoses included, but were not limited to, weakness, renal (kidney) failure, COPD (chronic obstructive pulmonary disease), pacemaker, amenia (decrease in the number of red blood	F 276	**F276 Quarterly Assessment at Least Every 3 months** It is the practice of this facility to assess residents using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #148 has a pressure risk assessment which reflects current status. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 276	Continued From page 26 cells), dermatitis (inflammation of the skin), and cellulitis (skin infection). Documentation was lacking to indicate a quarterly pressure wound risk assessment was completed within 92 days of the previous assessment. A pressure wound risk assessment, dated 09/18/2010, indicated the resident was at risk for developing skin breakdown. A care plan, dated 11/08/2010, identified risk for skin break down. Interventions included, but were not limited to, "...HEEL OFF LOADING BOOTS TO BILATERAL WHEN IN BED...Reposition at least every two hours...LOW AIR LOSS MATTRESS WITH BOLSTERS...." A 60 day scheduled MDS (Minimum Data Set Assessment), dated 12/19/2010, indicated the resident is totally dependent on two staff for bed mobility and transfers. The assessment indicated the resident had three Stage 2 pressure ulcers (bilateral buttocks and left lateral foot). During an interview on 01/27/2011 at 2:00 p.m., the DoN (Director of Nursing) indicated there had been no pressure assessment completed since 09/18/2010. During an interview on 01/27/2011 at 4:25 p.m., RN # 3 indicated resident assessments are supposed to be completed quarterly. Page 2-30 of CMS's RAI Version 3.0 Manual was provided by the DoN on 01/28/2011 at 3:00 p.m., as a facility policy for quarterly assessments. The manual indicated, "The Quarterly assessment ...must be completed at least every 92 days...It is used to track a resident's status between	F 276	• Residents who reside in the facility have the potential to be affected by the alleged deficient practice. • Nurse Managers will be re-educated on completion of quarterly assessments by Director of Nursing/designee by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • MDS Coordinator will provide a list of the assessments required to be completed each month to Director of Nursing. • Medical Records Clerk will ensure that the assessment packets are provided to the Nurse Managers. • Nurse Managers will complete the assessments by the designated date. • MDS Coordinator/designee is responsible to ensure compliance with facility procedure.	

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- An "Assessment" CQI tool will be completed weekly times four weeks then monthly times two months then quarterly thereafter.
- The CQI committee will review the data gathered and if threshold is not achieved, an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 276	Continued From page 27 comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored...." 3.1-31(d)(3)	F 276		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed related to medications, blood pressure and pulse monitoring, obtaining a urine specimen, compression stockings, fluid restrictions, and pressure ulcer prevention interventions. This deficient practice effected 5 of 24 residents reviewed for completed physician's orders in a sample of 24. (Residents # 11, #19, #26, #34, and #134) Findings include: 1a. Resident #26's record was reviewed on 1/28/11 at 10:00 a.m. Diagnoses for Resident #26 included, but were not limited to, anxiety, hypothyroidism, asthma, GERD (gastroesophageal reflux disease), dysphagia, history of CHF (congestive heart failure), hypertension, coronary artery disease, and atrial fibrillation. Documentation indicated the resident was admitted to the facility on 11/2/10.	F 282	**F282 Services by Qualified Persons/Per Care Plan** It is the practice of this facility to ensure services are provided or arranged by the facility to be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #26 the physician was notified in regards to the omission of the nebulizer treatments, blood pressure checks and pulses. • Resident #11 receives services as per physician orders. • Resident #34 wears her tenso stockings per physician orders. • Resident #134 has blue off loading boots to wear in bed per physician orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 28 Discharge instructions for the resident's admission to the facility, dated 11/2/10, indicated the resident was to receive "...Albuterol 0.083% nebulizer 3X/day one vial...." Review of the Medication Administration Records (MAR), dated 11/2/10 through 1/27/11, indicated the following: 11/2/10 through 11/30/10: "...Albuterol 0.083% neb (nebulizer)...three (3) times daily..." " A handwritten note on the Medication Administration Record (MAR) indicated "D/C (discontinue) 11/11/10." The MAR indicated the resident received the Albuterol nebulizer treatment two times on 11/3; two times on 11/4; once on 11/8, and once on 11/9. A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment 1 time on 11/3; three times on 11/4; two times on 11/5; three times on 11/7; two times on 11/8; once on 11/9; three times on 11/10; once on 11/11, and once on 11/12. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment from 11/13/10 through 11/30/10. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician. 12/1/10 through 12/31/10: "...Albuterol 0.083% neb... three times daily..." A handwritten note on the Medication Administration Record indicated "See flow sheet PRN." A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment once on 12/2; two times on	F 282	• Resident #19 receives tube feeding and flushes per physician orders. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents who reside in the facility have the potential to be affected by the alleged deficient practice. • Nursing staff were re-educated, by the Staff Development Coordinator/designee, in regards to ensuring devices and protective equipment are applied timely, by March 4, 2011. • Resident receives g-tube flushes and g-tube feeding with proper technique per physician order. • The licensed nurse will observe for proper placement of adaptive equipment and devices during rounds on their assigned shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 29 12/3; once on 12/4, and once on 12/5. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment at any time from 12/6/10 through 12/31/10. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician. 1/1/11 through 1/27/11: "...Albuterol 0.083% neb...three (3) times daily..." A handwritten note on the Medication Administration Record indicated "PRN." A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment once on 1/1/11 and once on 1/4/11. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment at any time from 1/5/11 through 1/27/11. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician. During an interview with the Director of Nursing (DoN) and the Corporate Nurse Specialist on 1/28/11 at 3:10 p.m., they indicated Resident #26 should have gotten the Albuterol nebulizer treatments three times per day since she was admitted. The DoN indicated she did not know why the medication had been changed to a PRN (as needed) order. She indicated she could not locate a physician's order to support why the nebulizer had been changed from a scheduled medication to a PRN by the staff. She indicated she understood the concern related to not following physician's orders related to the nebulizer. 1b. Review of the Medication Administration	F 282	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Nursing staff were re-educated, by the Staff Development Coordinator/designee, in regards to ensuring devices and protective equipment are applied timely. • Nurse Managers will assure that the resident care sheets are up to date with changes daily (Monday through Friday). • Nurse Managers will check the medication administration records three times per week to ensure physician orders are followed as ordered. • Licensed nurse skills validation for g-tube medication administration will be completed upon hire and no less than annual, to ensure competency. • DNS/designee is responsible to ensure compliance with facility procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 30 Records (MAR) for Resident #26, dated 11/2/10 through 1/27/11, indicated the following: "...Check BP (blood pressure) TID (three times per day)...." 11/2/10 through 11/30/10: A hand written note on the MAR indicated "...see Lisinopril (blood pressure medication) BID (two times per day)...." Documentation was lacking to indicate the blood pressures were taken TID as ordered by the physician on 11/3, 11/6, 11/9, 11/19, 11/20, and 11/28. 12/1/10 through 12/31/10: A hand written note on the MAR indicated "...see Lisinopril BID...." Documentation was lacking to indicate the blood pressures were taken TID as ordered by the physician on 12/3, 12/4, 12/6, 12/7, 12/11, 12/12, 12/14, 12/17, 12/19, 12/22, 12/23, 12/28, 12/29, and 12/30. 1/1/11 through 1/27/11: Documentation was lacking to indicate the blood pressures were taken TID as ordered by the physician on 1/2, 1/5, 1/11, 1/12, 1/13, 1/16, 1/17, 1/19, 1/20, 1/24, 1/25, 1/26, and 1/27. During an interview with the Director of Nursing (DoN) and RN#3 on 1/28/11 at 12:00 p.m., indicated the blood pressure was ordered to be taken three times per day. They indicated it should have been done three times per day and it had not been done. They indicated it was inappropriate to mark "see Lisinopril BID" on the MAR in place of the blood pressure documentation. During an interview with the DoN and the	F 282	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • A "MAR/TAR" CQI tool will be utilized three times per week for one month then weekly thereafter. • Licensed nurse skills validation for g-tube medication administration will be completed weekly times four weeks, monthly times two and quarterly thereafter. • A "Special Equipment/Device" CQI tool will be utilized three times per week times one month, weekly times two months then quarterly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 31 Corporate Nurse Specialist on 1/28/11 at 3:10 p.m., they indicated they were unable to locate any further information related to the blood pressures. They indicated the blood pressures should have been taken three times per day as ordered by the physician. 1c. Review of the Medication Administration Records (MAR) for Resident #26, dated 11/2/10 through 1/27/11, indicated the following: "...Digoxin (a heart medication) 125 mcg (micrograms) i (one) po (orally) qd (daily). Hold if pulse < (less than) 60...9 a.m...." 12/1/10 through 12/31/10: Documentation was lacking to indicate the pulses were taken at 9 a.m., prior to the administration of the medication as ordered by the physician on 12/21, 12/23, 12/24, and 12/30. A care plan, dated 11/2/10, indicated "...problem...at risk for adverse drug reaction, resident receives digoxin...approach...administer meds as ordered...check apical pulse prior to administering medication...." During an interview with the Director of Nursing (DoN) and RN #3 on 1/28/11 at 12:00 p.m., indicated the pulse should have been taken daily prior to the administration of the digoxin at 9 a.m. During an interview with the DoN and the Corporate Nurse Specialist on 1/28/11 at 3:10 p.m., they indicated they were unable to locate any further information related to the pulses. They indicated the pulses should have been taken daily as ordered by the physician prior to the administration of the 9 a.m., digoxin.	F 282	**Compliance date:** March 4, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 32	F 282		

2. The clinical record for Resident # 11 was reviewed on 2/4/11 at 9:55 A.M.

A physician's order, dated 12/29/10, indicated the resident was to have a urinalysis and culture and sensitivity (laboratory tests to determine the presence of a urinary tract infection) to rule out a possible urinary tract infection. There was no documentation on the physician's order to indicate the nursing staff were to obtain the specimen utilizing a straight catheter.

A nursing note, dated 12/29/10 at 10:15 P.M., indicated, "urine specimen obtained via straight catheter tolerated procedure well...."

During an interview with the Director of Nursing on 2/4/11 at 12:40 P.M., she indicated the staff did not have a physician's order to use a straight catheter to obtain the urine specimen. She indicated the staff should always obtain an order from the physician if they are going to obtain a specimen with a straight catheter.

3. The clinical record for Resident # 34 was reviewed on 02/02/2011 at 11:00 a.m.

Diagnoses included, but were not limited to, history of CVA (stroke), degenerative joint disease, edema (swelling) and history of cellulitis (skin infection).

A physician's order, printed on the 02/2011 Physician's Recapitulation indicated, "...RESIDENT TO WEAR TENOSCHAPE (SIC) STOCKINGS (compression stockings) ON BILATERAL LOWER EXT (extremities [legs]) DAILY TO DECREASE EDEMA,.RESIDENT TO DONN STOCKING DURING DAY OFF AT NIGHT..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 33	F 282		

During an observation on 02/04/2011 at 11:50 a.m., Resident # 34 was observed in bed without the compression stockings in place.

Documentation on the daily treatment record on 02/04/2011 at 11:52 a.m., indicated the stockings were in place.

During an interview on 02/04/2011 at 11:55 a.m., RN # 19 indicated her initials on the treatment record indicated she had placed the stockings on the resident. The RN indicated the stockings were not in place and that she did not remember putting them on the resident earlier. The stockings were located in the resident's closet and applied after the ADoN verified the stockings were not in place and that they should have been on if the treatment sheet was initialed.

4. The clinical record for Resident # 134 was reviewed on 01/26/2011 at 2:50 p.m.

Diagnoses included, but were not limited to, renal (kidney) failure, severe protein malnutrition, venous stasis (slow blood flow through veins) ulcer, right lower extremity, deep vein thrombosis (blood clot), hypertension (high blood pressure), and depression.

A physician's order, dated 10/28/2010, indicated "...Res (resident) to wear blue off loading boots at all times while in bed...."

The MDS (Minimum Data Set) Assessment, dated 12/01/2010, indicated Resident # 134 was at risk for pressure ulcers.

A care plan for keeping resident free from further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 34 skin breakdown, dated 12/06/2010, indicated "...ROUTINELY SCHEDULED TX (treatment) AS ORDERED AND Preventative (SIC) treatment as ordered...." During observations on 01/24/2011 at 11:30 a.m., and 4:25 p.m., 01/25/2011 at 11:00 a.m., and 3:00 p.m., 01/26/2011 at 9:00 a.m., 1:00 p.m., 4:00 p.m., and 01/27/2011 at 9:00 a.m., the resident was observed without off loading boots. During an interview on 01/27/2011 at 9:00 a.m., RN # 3 indicated the resident should have been wearing off loading boots but none were in place. During an interview on 01/27/2011 at 9:05 a.m., LPN # 1 indicated she could not locate the resident's off loading boots and had to obtain a new pair. 5. The clinical record of Resident # 19 was reviewed on 01/26/2011 at 10:45 a.m. Diagnoses for Resident # 19 included, but were not limited to, CHF (congestive heart failure), diabetes type 2, anemia (decreased number of red blood cells), altered mental status, cardiomyopathy (deterioration of the function of the heart muscle), and acute renal (kidney) failure. Physician's orders printed on the January 2011 Physician's Recapitulation indicated, "...1500 CC (cubic centimeters) FLUID RESTRICTION ...FLUSH TUBE PRIOR TO AND AFTER MEDICATION ADMINISTRATION WITH 30 CC WATER...FLUSH TUBE WITH 240 CC THREE TIMES DAILY...SUPLENA VANILLA 8 OZ (ounces) 45 CC/HR (hour) X (times) 24 HRS	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 35 (hours).... " During an interview on 01/27/2011 at 9:45 a.m., the RD (Registered Dietitian) indicated she did not include flushes between medications when calculating the resident's daily fluid intake. She indicated the resident had been receiving 2174 cc of fluid per day. During an interview on 01/27/2011 at 10:30 a.m., the corporate nurse consultant indicated the facility did not have a policy for fluid restriction and that the facility is supposed to follow physician orders for fluid restrictions. 3.1-35(g)(2)	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident received bowel management interventions following a period of time without a bowel movement. This deficient practice affected 1 of 24 residents reviewed for bowel management in a total sample of 24 residents. (Resident # 116) Findings include:	F 309	**F309 Provide Care/Services for Highest Well Being** It is the practice of this facility to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #116 had a bowel assessment that was completed with physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 36 The clinical record for Resident # 116 was reviewed on 1/28/11 at 11:40 A.M. Diagnoses for the resident included, but were not limited to, gastroesophageal reflux disease, hypertension, and hypothyroidism. Review of a quarterly minimum data set assessment, dated 10/15/10, indicated the resident was incontinent of bowel all or almost all of the time. A current care plan for the resident, initially dated 1/15/11, indicated the resident was at risk for constipation related to decreased mobility and medications. Interventions related to this concern indicated staff were to monitor the resident's bowel function, notify the physician if no bowel movement by the 3rd day, and administer medications as ordered. Review of the physician's order summary for 2/11, indicated the resident had the following orders for bowel management: Docusate sodium (a stool softener) 200 milligrams by mouth once daily at bedtime Milk of Magnesia (a laxative) 30 milliliters by mouth once daily as needed for constipation Bisacodyl suppository 10 milligrams once daily as needed for constipation. Review of the "ADL (activities of dally living) Record" for 12/10, indicated the resident did not have a bowel movement from 12/12/10 through 12/15/10.	F 309	notification. Resident is currently having regular bowel movements every two to three days. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents who reside at the facility have the potential to be affected by the alleged deficient practice. • Nurse Managers reviewed all the bowel records to ensure that there were not any residents at risk for bowel issues. • Licensed staff have been re-educated regarding bowel assessments, by the Staff Development Coordinator/designee by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

- Bowel/Bladder records will be reviewed in morning meeting (Monday thru Friday) to ensure that residents are not having bowel issues.
- Licensed Nurses will check BM records on a daily basis.
- Certified Nursing Assistants will be re-educated to report to their charge nurse, residents with no BM's for two days or greater by the Staff Development Coordinator/designee by March 4th, 2011.
- A bowel assessment will be completed on residents who don't have a bowel movement for three days. Medications will be administered per orders and physician will be notified on day 4 if still no bowel movement occurs.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 37 Review of the Medication Administration Record (MAR) indicated the resident did not receive any bowel management interventions during that time period. There was no documentation in the clinical record to indicate the nursing staff completed an abdominal assessment of the resident or administered bowel management interventions during the time she did not have a bowel movement. During an interview with the Director of Nursing on 1/28/11 at 4:11 P.M., she indicated the nursing staff should have completed an abdominal assessment at the time the resident did not have a bowel movement. She indicated she had looked at the clinical record and the 24 hour report sheets, and she was not able to find a documented assessment or where staff had administered bowel management medications. She indicated typically after the third day with no bowel the resident would receive Milk of Magnesia and then on the fourth day with no bowel movement the resident would receive another intervention. She indicated the facility did not have a bowel management policy.	F 309	• A "Bowel Elimination" CQI tool will be utilized two times per week times one month, weekly times two months then quarterly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	
F 315 SS=D	3.1-37(a) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate	F 315	**F315 No Catheter, Prevent UTI, Restore Bladder** It is the practice of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 38 treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident with a urinary tract infection received prompt treatment which resulted in an increase in confusion, anxiety, and agitation for the resident. This deficient practice effected 1 of 4 residents reviewed for prompt treatment of urinary tract infections in a sample of 24. (Resident #26) Findings include: Resident # 26's record was reviewed on 1/28/11 at 10:00 a.m. Diagnoses for Resident #26 included, but were not limited to, anxiety, recurrent UTI (urinary tract infection), and dementia. A care plan, dated 11/2/10, indicated "...problem...resident has a history of chronic urinary tract infection...approach...encourage fluids, assist with incontinent care if needed, remind resident of proper cleaning, observe for signs/symptoms of UTI: cloudy/foul smelling urine, c/o (complaints of) frequency, urgency, or burning with urination, abdominal or flank pain, fever, change in mental status, document abnormal findings and notify MD...." A physician's order, dated 12/27/10, indicated "...straight cath (urinary catheterization) for UA/ C+S (urinary catheterization/cultures and sensitivity) 12/28/10...." A care plan attached to	F 315	demonstrates that catheterization was necessary; and a resident who in incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **F315 IS BEING DISPUTED. THE FOLLOWING IS THE PLAN OF CORRECTION.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #26 was treated with antibiotics. Resident has a diagnosis of Chronic Urinary Tract Infections. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents with UTI's have the potential to be affected by the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 39 the physician's orders indicated "...problem increased (arrow up) agitation, anxiety + confusion...interventions...str (straight) cath/ UA/C+S...." The Interdisciplinary team progress notes indicated the following: "...12/23/10 9:35 am...on 12/22/10 @ (at) 12:30 pm res attempted to take her roommate downstairs for bowling staff explained that her roommate does not bowl. Res became agitated about her roommate not going. Res went down to club room @12:30 pm et (and) stated she was going to wait there for bowling which didn't start until 2 pm. Res refused to go upstairs & eat...res stayed in club room until bowling but then left when it started. Team discussed that res has been increasingly confused. Team discussed notifying MD for UA C&S...." "...1/5/11 9:30 am...on 1/4/11 @ 9:40 pm res was yelling @ the nurse d/t stated she didn't get her meds p (after) nurse had just given her the meds. Res is just started on Septra DS x 5 days d/t (due to) UTI..." "...1/7/11 9 am...on 1/6/11 @ 11:30 pm res was talking to CNA res said she sees things, know they really aren't true. Res says she sees naked ppl (people), feels ppl are out to get her. Team discussed res is being treated for a UTI..." Review of the nurses' notes indicated documentation was lacking related to the increased confusion and agitation that prompted the staff to call the physician to get an order to obtain the UA/C+S.	F 315	• Licensed nursing staff were re-educated on lab follow thru, physician notification of condition changes and monitoring for signs and symptoms of UTI's; by the Staff Development Coordinator/designee by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Upon hire, annually and as needed; Certified Nursing Assistants are re-educated on peri-care, hydration and toileting. • Quarterly licensed nursing staff will complete a hydration and toileting assessment on residents. • Lab orders are reviewed in the morning clinical meeting (Monday – Friday). • Lab binders will be brought to the morning clinical meeting (Monday – Friday) to review for the completion of labs. • Requisitions will be completed at the time of collection.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 40 The nurses' notes indicated the following: "...12/27/10 9a, res...has had increased (arrow up) anxiety + (and) agitation...confusion...." "...12/28/10 9:30 p.m., UA/C+S obtained. Awaiting lab pick up...0 (no) c/o (complaints of) pain or discomfort...." Documentation was lacking to indicate fluid consumption or urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. Documentation was lacking in the nurses notes' from 12/28/10 through 12/30/10 at 2:45 p.m., related to fluid consumption or urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...12/30/10 2:45 p.m., UA results returned from M.D. Awaiting C+S + colony count. Will fax MD when available...." Documentation was lacking to indicate fluid consumption or urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. A laboratory result C+S laboratory results sheet for Resident #26 dated 12/29/10, indicated there was a hand written note identifying the physician had been faxed the results on 12/31/10. The nurses' notes continue: "...1/1/11 2pm...ATB for UTI continues. VSS (vital signs) 128/74, 60, 18, 98.2...." Documentation	F 315	• Notify lab and document on the 24 – hour report. • When lab results return notify physician for clinical course. • DNS/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • A "Lab Diagnostic" CQI tool will be utilized weekly times one month, monthly times two then quarterly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 41 was lacking to indicate the physician had prescribed antibiotics to treat the resident's UTI at this time. Documentation was lacking related to fluid consumption or urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...1/2/11 11 am...res stated that she was raped by someone last night + she heard other people in the hall talking about a bomb. Res is confused most of the time + when asked if anyone touched her she said no. Res had U/A + lab work done the 12/28/10. MD notified + said not to do anything + we are still awaiting C+S + colony count. MD said to get with SS (social services) on Monday...ongoing investigation....." Documentation was lacking to indicate the physician was made aware on 1/2/11 the results of the C+S and colony count. Documentation was lacking to indicate fluid consumption was being addressed or a urinary assessment had been completed. A full investigation into the resident's allegation of rape was reviewed and no concerns were identified. The allegation was unsubstantiated. Documentation was lacking in the nurses' notes related to fluid status or a urinary assessment having been completed from 1/2/11 at 11:00 a.m., through 1/4/11 at 9:00 a.m. A physician's order, dated 1/3/11, indicated "...Septra DS (antibiotic) i (one) po (orally) BID (two times per day) x (times) 5 days for UTI...." The nurses' notes indicated the following:	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 42 "...1/4/11 9a (a.m.)...on ATB (antibiotic) therapy for UTI. T (temperature) 97.1. 0 (no) AVR (adverse reactions) noted...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...1/4/11 7:25 p.m.,..ATB continues s (without) s/s (signs/symptoms) adverse effects..." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...1/5/11 11 am, Continues on ATB-UTI. 0 AVR noted. No c/o pain or discomfort...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...1/5/11 8:30 pm, Res continues on ATB/UTI. Temp 98.2...0 c/o pain or discomfort...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. "...1/6/11 2 am, Res continues on ATB therapy for UTI. T-98.0. 0 AVR noted.) c/o pain or discomfort...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 43 experiencing agitation, anxiety, or confusion. Documentation was lacking related to fluid status or a urinary assessment having been completed from 1/6/11 at 2:00 a.m., until 1/7/11 at 11: 00 a.m. "...1/7/11 12 am, Res up in dining room, making negative statements, repetitive verbalizations, + unrealistic fears...1:1 attention given...." "...1/7/11 11 am, Continues on ATB-UTI. 0 AVR noted. T 97.4 0 c/o pain or discomfort...." Documentation was lacking related to fluid consumption or a urinary assessment having been completed. Documentation was lacking to indicate whether the resident was experiencing agitation, anxiety, or confusion. Resident #26's weight records indicated the resident weighed 130 pounds (59.09) kilograms in January 2011. An admission nutritional assessment dated 11/9/10 indicated the estimated fluid needs per day for this resident would be 1652- 1770 mL's of fluids per day. A food/fluid intake record and the Medication administration records, dated 12/27/10 through 1/8/11, indicated the resident consumed the following: 12/27: 1760 milliliters (mL) 12/28: 1800 mL 12/29: 1800 mL 12/30: 1740 mL 12/31: 1740 mL 1/1: 1440 mL	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 44 1/2: 1340 mL 1/3: 1620 mL 1/4: 1260 mL 1/5: 1740 mL 1/6: 2040 mL 1/7: 1680 mL 1/8: 1660 mL Documentation was lacking to indicate the resident consumed an increased amount of fluids during the days before she was identified as having a UTI and during treatment of the UTI. An interview with the Director of Nursing (DoN), LPN #6, and RN #3, on 1/28/11 at 12:00 p.m., indicated over the weekends the on-call physician is to be notified for any resident concern. The DoN indicated if it is not a weekend, the staff were to call and fax the physician related to any resident concerns. The DoN indicated the staff should have called the MD to get treatment for the resident's UTI. She indicated the staff should have gotten treatment from the physician prior to 1/3/11. She indicated the nurse manager on call over the weekend was responsible for ensuring staff obtain treatment for any infections. She indicated the nurse manager in charge at that time had since been terminated. The DoN indicated the staff should have been addressing hydration, offering a water pitcher every shift and 2-3 glasses of fluids with every meal. They indicated they would expect to see documentation related to encouraging and offering extra fluids every shift in the nurses' notes and on the intake consumption sheets. They indicated the resident would not have been able to be educated at that time due to the behaviors and agitation she had been experiencing at the time.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 45 An interview with the DoN and the Corporate DNS Specialist on 1/28/11 at 3:10 p.m., indicated there was no specific policy related to UTI prevention and treatment. The DoN indicated standards of practice are utilized such as extra fluids, cranberry juice, perineal care assistance, and prompt physician treatment. The DoN indicated she had "no excuse" for the delay in treatment from the time the C & S was obtained from the lab on 12/31/10 and the ordering of treatment from the physician. During an interview with LPN #10 on 12/31/11 at 8:25 a.m., she indicated assessments for a resident with a UTI included urinary output, color of urine, frequency of urine, urgency with urination, pain with urination, temperature of the resident, and fluids should be encouraged. She indicated all this information should be documented on every shift. She indicated documentation of urinary assessments and documentation related to fluids were lacking for Resident #26. During an interview with LPN #6 on 12/31/11 at 8:35 a.m., she indicated assessments for a resident with a UTI included vital signs, urinary output, color of urine, frequency of urine, odor of urine, dysuria, pain with urination, and fluids should be encouraged. She indicated all this information should be documented on every shift. She indicated documentation of urinary assessments and documentation related to fluids were lacking for Resident #26. During an interview with the DoN on 12/31/11 at 8:40 a.m., she indicated assessments for a resident with a UTI included every shift documentation of burning upon urination, odor of	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 46	F 315		

urine, color of urine, vitals of the resident, response to antibiotics, pain upon urination, and acceptance of fluids. The DoN indicated the staff were not documenting assessments of the resident every shift. She indicated she was not seeing documentation of acceptance of increased fluids. She indicated she had concerns with staff assessment and documentation related to the UTI for Resident # 26.

During an interview with the Dietary Manager/Registered Dietitian on 2/4/11 at 9:00 a.m., she indicated staff should be encouraging fluids for resident's with urinary tract infections. She indicated she would expect to see documentation of fluids to be above what the resident would normally take in on a regular basis.

During an interview with LPN #2 on 2/4/11 at 9:20 a.m., she indicated staff were to encourage fluids during med pass, while in providing care, and with snacks. She indicated staff were to document fluids on the food/fluid intake sheets, and in the nurses' notes. She indicated nurses should document whether the resident was receptive to fluids or refused.

During an interview with CNA # 12 on 2/4/11 at 9:25 a.m., she indicated when a resident has a UTI the staff encourage the resident to drink more fluids. She indicated the amount of fluids consumed by the resident would be documented on the food/fluid intake sheets.

During an interview with CNA # 13 on 2/4/11 at 10:35 a.m., she indicated when a resident has a UTI the staff encourage the resident to drink more fluids. She indicated the amount of fluids

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 47 consumed by the resident would be documented on the food/fluid intake sheets. During an interview with CNA # 14 on 2/4/11 at 10:40 a.m., she indicated when a resident has a UTI the staff encourage the resident to drink more fluids. She indicated the amount of fluids consumed by the resident would be documented on the food/fluid intake sheets. 3.1-41(a)(1)	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were administered with proper technique for a resident with a gastrostomy tube (g-tube). This affected 1 of 1 residents reviewed for g-tube medication administration in a total sample of 24 residents. (Resident #89). Findings include: During a medication observation on 1/25/11 at 8:40 a.m., with RN #9 and the Director of Nursing (DoN) the following was observed:	F 322	**F322 NG Treatment/Services-restore Eating Skills** It is the practice of this provider to ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration, pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #89 receives g-tube medication utilizing proper technique. Resident is currently engaged in therapy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 48 The RN prepared Resident #89's medications as ordered by the physician with each medication in its own plastic medication cup. The RN entered the resident's room and placed each medication on the table next to the resident's bed. The RN checked the residual feeding present in the resident's g-tube and checked the placement of the tube via air bolus. The RN flushed the resident's g-tube with 30 milliliters (mL) of water before beginning the medication administration. The RN held the resident's g-tube in his left hand, and using his right hand placed the syringe and piston into one of the cups that contained the resident's medication and 10 ml water flush. The RN aspirated the medication into the syringe using his right hand and then placed the syringe into the resident's g-tube. The RN pushed on the piston forcing the medication and water to enter the resident's g-tube. The RN repeated this sequence again. The RN began to do the same sequence a third time and the DoN interjected and told him not to force the medication and water flush into the resident's g-tube. The RN placed the syringe and piston into the resident's g-tube and pulled the piston from the end of the syringe which caused the feeding present in the resident's stomach to aspirate into the syringe and mix with the medication and water. The RN indicated he did this in an effort to "allow the medication to flow easier into the tube and not get plugged up in the feeding tube." The RN repeated the process three more times until the resident's medications were passed. The RN then flushed the resident's g-tube with 30 mL's of water and began the resident's tube feeding. During the medication administration the RN was observed repeatedly pulling and placing tension on the resident's feeding tube while trying to	F 322	and discharge plans are for her to return to home. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents that utilize g-tubes have the potential to be affected by the alleged deficient practice. • Nursing staff was re-educated on medication administration utilizing proper technique via g-tube, by the Staff Development Coordinator/designee, by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Licensed Nurses completed a skills validation on g-tube medication administration by the Staff Development Coordinator/designee, by March 4, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 49 aspirate the medications from the medication cup into the syringe. The resident's skin at the g-tube insertion site was pulling away from her abdomen due to the tension in the tube. The resident was observed placing a hand on her abdomen at the g-tube insertion site in an effort to keep the tube in place. The RN was observed during the administration dripping medications and water from the end of the syringe on to the resident's personal items located on the bedside table, on the resident's arm, on the resident's bed linens, and on the resident's gown. During an interview with the RN immediately following the observation, he indicated he "would not normally push the medications into the g-tube via the piston." He indicated the medications should have been administered via gravity. He indicated he was unaware he was pulling on the resident's g-tube during the administration. During an interview with the DoN immediately following the observation, she indicated the RN should have placed the syringe into the resident's g-tube and administered each medication and water flush via gravity. She indicated medications and water should never be forced into the g-tube. She indicated it is inappropriate to pull or place tension on a g-tube. She indicated the medication administration was not done per facility policy. During an interview with Resident #89 on 1/25/11 at 9:35 a.m., she indicated the RN did pull on the g-tube, but it did not hurt her, it was just uncomfortable. She indicated she put her hand over the insertion site to keep the tube from pulling and ensure the g-tube stayed in place.	F 322	• Upon hire and no less that annually a skills validation will be completed to ensure competency of g-tube medication administration. • DNS/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • A g-tube skills validation will be completed three times weekly times four weeks, monthly times two and quarterly thereafter by the Staff Development Coordinator/designee. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 50 3.1-44(a)(2)	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fall prevention interventions were in place for 1 of 6 residents reviewed for falls in a sample of 24 residents (Resident # 128). Findings include: The clinical record for Resident # 128 was reviewed on 01/28/2011 at 11:10 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, osteoporosis, arthritis, and depression. A "Fall Risk Assessment," dated 11/13/2010, indicated, "... the resident is at risk for experiencing a fall...." Nurse's notes, dated 01/18/2011 at 10 a.m., indicated, "...Res (resident) was getting up from bed to chair slipped in fluid slipped to floor...MD (medical doctor) notified orders to sent to ER (emergency room) for eval (evaluation)...	F 323	**F323 Free of Accident Hazards/Supervision/Devices** It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #128 has a fall risk assessment with interventions that reflect resident's current status. Resident has fall interventions in place and has not experienced any further falls. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 51 A "Fall Circumstance Report," dated 01/18/2011 at 10:00 a.m., indicated, "... Bed pad alarm. Gripper socks while in bed..." were interventions put in place to prevent another fall. An "Interdisciplinary Team Progress Note," dated 01/19/2011 at 10:00 a.m., indicated, "...Team also reviewed that res (resident) will be on 30 min (minute) checks while in bed d/t (due to) the limitations...." A care plan for "RISK FOR FALLS," dated 01/19/2011, indicated, "...30 min (minute) (symbol for checks) while in bed to assure safety d/t (due to) limitations (symbol for with) shoulder fx (fracture)...." Documentation was lacking to indicate bed checks had been completed. During an interview on 01/28/2011 at 11:50 a.m., RN # 3 indicated the documentation for bed checks should have been in the treatment book. She was unable to locate the documentation. During an interview on 02/04/2011 at 10:15 a.m., the DoN (Director of Nursing) indicated the facility was not able to locate documentation of bed checks. She indicated there was no documentation to verify the bed checks had occurred. A policy titled "Fall Management Program," dated 07/01 and reviewed 03/10, was provided by the DoN on 02/04/2011 at 11:00 a.m. The policy indicated, "...the interdisciplinary team...to determine other possible interventions to prevent future falls...."	F 323	• Residents who are at fall risk have the potential to be affected by the alleged deficient practice. • Nursing staff were re-educated on following care plan/orders for resident's, by the Staff Development Coordinator/ designee, by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Licensed nurses round to ensure fall interventions are in place and the safety of our residents throughout their shift. • Falls will be reviewed in the morning clinical meeting (Monday through Friday) with interventions and care plans updated to ensure changes are made for safety. Nurse Managers will review on the weekends. • Fall risk assessments are completed at admission, re-admission, quarterly, annual and with a significant change.	

- A fall circumstance is completed with immediate interventions to keep residents safe.
- IDT to review falls in morning clinical meeting (Monday through Friday) to determine interventions and root cause.
- Care plan and nurse aid assignment sheet are updated after each fall to reflect current status.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

- Licensed nurses round to ensure fall interventions are in place and the safety of our residents throughout their shift.
- A "Fall Management" CQI tool be completed weekly times four weeks, monthly times two and quarterly thereafter.

- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 52 3.1-45(a)(2)	F 323	**F328 Treatment/Care for Special Needs** It is the practice of this facility to ensure that residents receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy, uretrostomy or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a resident received respiratory nebulizer treatments as ordered by the physician due to respiratory nebulizer inhalation medication having been mistakenly changed from a scheduled medication to be given three times per day to PRN (as needed) medication and incorrect oxygen administration. This deficient practice effected 2 of 24 resident's reviewed for respiratory care and treatment in a sample of 24. (Residents #19 and #26) Findings include: 1. Resident #26's record was reviewed on 1/28/11 at 10:00 a.m. Diagnoses for Resident #26 included, but were note limited to, anxiety, hypothyroidism, asthma, GERD (gastroesophageal reflux disease), dysphagia	F 328	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #26 the physician was notified in regards to the omission of the nebulizer treatments, blood pressure checks and pulses. • Resident # 19 receives O2 as ordered by physician, with saturations of 92 to 96 percent. Physician was notified of altered rate. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 53 (difficulty swallowing), history of CHF (congestive heart failure), hypertension, coronary artery disease, and atrial fibrillation. Documentation indicated the resident was admitted to the facility on 11/2/10. Discharge instructions for the resident's admission, dated 11/2/10, indicated the resident was to receive "...Albuterol 0.083% nebulizer 3X/day one vial...." Review of the Medication Administration Records (MAR), dated 11/2/10 through 1/27/11, indicated the following: 11/2/10 through 11/30/10: "...Albuterol 0.083% neb (nebulizer) tid (three time per day)..." A handwritten note on the Medication Administration Record indicated "D/C (discontinue) 11/11/10." The MAR indicated the resident received the Albuterol nebulizer treatment two times on 11/3; two times on 11/4; once on 11/8, and once on 11/9. A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment 1 time on 11/3; three times on 11/4; two times on 11/5; three times on 11/7; two times on 11/8; once on 11/9; three times on 11/10; once on 11/11, and once on 11/12. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment from 11/13/10 through 11/30/10. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician. 12/1/10 through 12/31/10: "...Albuterol 0.083% neb (nebulizer) tid (three time per day)..." A	F 328	• Residents who receive nebulizer treatments and / or utilize oxygen have the potential to be affected by the alleged deficient practice. • Nursing staff were re-educated, by the Staff Development Coordinator/designee, on ensuring orders and assessments are complete, by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • The licensed nurse will ensure physician orders are being followed during rounds on their assigned shift. • Nurse Managers audit daily for completion of flow sheets. • Nurse Managers round daily to ensure O2 is provided per physician order. • DNS/designee is responsible to ensure compliance with facility procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 54 handwritten note on the Medication Administration Record indicated "See flow sheet PRN." A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment once on 12/2; two times on 12/3; once on 12/4, and once on 12/5. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment at any time from 12/6/10 through 12/31/10. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician. 1/1/11 through 1/27/11: "...Albuterol 0.083% neb...three (3) times daily..." A handwritten note on the Medication Administration Record indicated "PRN." A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment once on 1/1 and once on 1/4. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment at any time from 1/5/11 through 1/27/11. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician. The nurses notes indicated the following: "...12/23/10 1 p (p.m.), Res (resident) c/o sore throat, cough, has nasal congestion lungs clear notified MD await reply...." Documentation was lacking related to vitals having been obtained. "...12/23/10 4:45 pm N.O. (new order) Z-pak (antibiotic) po (orally) ii (two) initial dose, then i	F 328	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** • A "MAR/TAR Flow sheet" CQI tool will be utilized three times per week for one month then weekly thereafter. • An "Oxygen Therapy" CQI tool will be utilized weekly times four weeks, monthly times two and quarterly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility procedure may result in employee education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 55	F 328		

(one) tab (tablet) x 4 days/URI (upper respiratory infection)...." Documentation was lacking to indicate a respiratory assessment and vitals had been completed.

"...12/24/10 12 am Res resting, quietly in bed. T 97.0. 0 (no) c/o sore throat. 0 SOB(shortness of breath), cough noted at this time. 0 c/o pain/discomfort...." Documentation was lacking to indicate a lung assessment of the resident had been completed.

Documentation was lacking to indicate any assessment related to respiratory status or the use of antibiotic had been documented in the nurses notes from 12/24/10 at 12:00 a.m., through 12/25/10 at 9:45 a.m.

"12/25/10 9:45 am...T (temperature) 98.6, p (pulse) 68, r (respirations) 18, b/p (blood pressure)111/68, SpO2 (oxygen saturation) 96% on room air. ATB (antibiotic) continues S (without) s/s (signs/symptoms) adverse effects...." Documentation was lacking to indicate what the lungs sounded like and if there was any cough or sore throat.

Documentation was lacking in the nurses' notes related to a respiratory assessment having been completed from 12/25/10 at 9:45 a.m., through 12/27/10 when the resident completed the antibiotic to treat the upper respiratory infection.

During an interview with the Director of Nursing on 1/28/11 at 3:10 p.m., she indicated Resident #26 should have gotten the Albuterol nebulizer treatments three times per day since she was admitted. She indicated she did not know why the medication had been changed to a PRN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 56	F 328		

order. She indicated she could not locate a physician's order to support why the nebulizer had been changed from a scheduled medication to a PRN by the staff. She indicated she understood the concern related to the medication error.

During an interview with LPN #10 on 12/31/11 at 8:25 a.m., she indicated assessments should be done and documented on every shift. She indicated the assessment should include temperature, lung sounds, cough, shortness of breath. She indicated the assessment should include any documentation related to the respiratory status of the resident. She indicated the assessments in the resident's chart were lacking information and had not been completed every shift. She indicated the resident should have been getting the nebulizer treatments three times per day.

During an interview with LPN #6 on 12/31/11 at 8:35 a.m., she indicated respiratory assessments of the resident should have been done every shift. She indicated the assessment should include information related to auscultation of the lungs, vitals, sputum production, cough, shortness of breath. She indicated the assessments were not done appropriately.

During an interview with the Director of Nursing on 12/31/11 at 8:40 a.m., she indicated staff should have been assessing Resident #26's respiratory status every shift. She indicated the assessments should include lung sounds, temperature, cough, shortness of breath, need for oxygen, and pain. She indicated she had concerns with the lack of assessments from nursing staff. She indicated she did not have a specific policy to provide related to the concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 57 2. The record of Resident # 19 was reviewed on 01/26/2011 at 10:45 a.m. Diagnoses for Resident #19 included, but were not limited to, CHF (congestive heart failure), diabetes type 2, anemia, altered mental status, cardiomyopathy (deterioration of the function of the heart muscle), and acute renal (kidney) failure. A physician's order, dated 10/27/2010, indicated "O2 (oxygen) @ (at 2 L (liters per minute) per nasal canula (a device used to deliver supplemental oxygen through the nasal passages) ...." A health care plan for ineffective tissue perfusion related to cardiac diagnosis, dated 01/24/2011, indicated, "...Observe for and document: ...shortness of breath...abnormal O2 (oxygen) sats (saturation). Notify MD (medical doctor)...." During observations on 1/24/2011 at 11:30 a.m., 4:15 p.m.; 01/25/11 at 10 a.m.; 01/26/2011 at 9:20 a.m., 11:00 a.m., 4:20 p.m., and 01/27/2011 at 8:45 a.m., the oxygen was being delivered at 1 1/2 liters per minute via nasal canula. During an interview on 01/27/2011 at 9:30 a.m., RN # 1 indicated the oxygen setting was 1 1/2 liters per minute and should have been at a delivery rate of 2 liters per minute. During an interview on 01/27/2011 at 2:00 p.m., the DoN (Director of Nursing) indicated the facility did not have a formal policy for oxygen delivery and that the facility referenced the physician's orders to determine the oxygen setting.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 58 3.1-47(a)(6)	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure AIMS (abnormal involuntary movement scale) assessments were completed to monitor for adverse affects of the medication, Reglan, for 1 of 24 residents reviewed for medications with potential for negative side effects in a sample of 24 residents. (Resident #	F 329	**F329 Drug Regimen is Free From Unnecessary Drugs** It is the practice of this facility to ensure that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences, which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #19 AIMS was completed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 59 19) Findings include: The clinical record of Resident # 19 was reviewed on 01/26/2011 at 10:45 a.m. Diagnoses for Resident # 19 included, but were not limited to, CHF (congestive heart failure), diabetes type 2, anemia (decreased number of red blood cells), altered mental status, cardiomyopathy (deterioration of the function of the heart muscle), and acute renal (kidney) failure. A physician's order, dated 08/24/2010, indicated, "Metoclopram (Reglan, a medication used to treat heartburn caused by acid reflux) 5 mg (milligram) tab (tablet). Take 1 tablet per PEG (feeding tube) tube once daily." A facility care plan for adverse medication side effects, dated 01/24/2011, indicated, "AIMS (abnormal involuntary movement scale) assessment two times a year..." Documentation was lacking to indicate an AIMS assessment had been completed for the resident. During an interview on 01/27/2011 at 2:00 p.m., the DoN (Director of Nursing) indicated the resident had not had AIMS assessment. Patient monitoring instructions listed in the "2010 Nursing Spectrum DRUG Handbook" indicated, "Watch for extrapyramidal (involuntary movement of face, eyes, or limbs) reactions..." 3.1-48(a)(3)	F 329	• Residents who receive antipsychotic / gastrointestinal medications have the potential to be affected by the alleged deficient practice. • Director of Nursing Service Specialist re-educated the DNS / ADNS on the completion of AIMS for residents who receive antipsychotic / gastrointestinal medications, by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • An audit was conducted by the DNS/designee to ensure that AIMS testing was completed for residents utilizing antipsychotic / gastrointestinal medications. • The Pharmacist review residents' clinical records monthly for excessive duration of drug usage, adequate monitoring and presence of adverse consequences.	

- An AIMS is completed upon admission and every six months thereafter for use of antipsychotic / gastrointestinal medications.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- An "Assessment" CQI tool will be completed weekly times four weeks then monthly times two months then quarterly thereafter.
- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure potentially significant medication errors did not occur related to a respiratory nebulizer inhalation medication having been mistakenly changed from a scheduled medication to be given three times per day to PRN (as needed) medication. This deficient practice effected 1 of 24 resident's reviewed for significant medication errors in a sample of 24. (Resident #26) Findings include: 1. Resident #26's record was reviewed on 1/28/11 at 10:00 a.m. Diagnoses for Resident #26 included, but were note limited to, anxiety, hypothyroidism, asthma, GERD (gastroesophageal reflux disease), dysphagia, history of CHF (congestive heart failure), hypertension, coronary artery disease, and atrial fibrillation. Documentation indicated the resident was admitted to the facility on 11/2/10. Discharge instructions for the resident's admission, dated 11/2/10, indicated the resident was to receive "...Albuterol 0.083% nebulizer 3X/day one vial...." Review of the Medication Administration Records (MAR), dated 11/2/10 through 1/27/11, indicated the following:	F 333	**F 333 Residents Free of Significant Med Errors** It is the practice of this facility to ensure that residents are free of any significant medication errors. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #26 the physician was notified in regards to the omission of the nebulizer treatments. Resident currently continues with nebulizer treatments PRN for respiratory distress. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents who reside at the facility have the potential to be affected by the alleged deficient practice. • Nursing staff were re-educated, by the Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 61 11/2/10 through 11/30/10: "...Albuterol 0.083% neb (nebulizer) tid (three time per day)..." A handwritten note on the Medication Administration Record indicated "D/C (discontinue) 11/11/10." The MAR indicated the resident received the Albuterol nebulizer treatment two times on 11/3; two times on 11/4; once on 11/8, and once on 11/9. A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment 1 time on 11/3: three times on 11/4; two times on 11/5; three times on 11/7; two times on 11/8; once on 11/9; three times on 11/10; once on 11/11, and once on 11/12. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment from 11/13/10 through 11/30/10. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician. 12/1/10 through 12/31/10: "...Albuterol 0.083% neb (nebulizer) tid (three time per day)..." A handwritten note on the Medication Administration Record indicated "See flow sheet PRN." A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment once on 12/2; two times on 12/3; once on 12/4, and once on 12/5. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment at any time from 12/6/10 through 12/31/10. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician.	F 333	Coordinator/designee, in regards to ensuring orders are completed correctly and assessments are completed as indicated, by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Nursing staff were re-educated, by the Staff Development Coordinator/designee, in regards to ensuring orders are completed correctly and assessments are completed as indicated, by March 4, 2011. • Nursing staff were re-educated on nebulizer forms, by the Staff Development Coordinator / designee, by March 4, 2011. • Nurse Managers audit daily for completion of flow sheets. • DNS/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 62 1/1/11 through 1/27/11: "...Albuterol 0.083% neb...three (3) times daily..." A handwritten note on the Medication Administration Record indicated "PRN." A nebulizer treatment flow sheet attached to the MAR indicated the resident received the Albuterol nebulizer treatment once on 1/1 and once on 1/4. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment at any time from 1/5/11 through 1/27/11. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician. During an interview with the Director of Nursing on 1/28/11 at 3:10 p.m., she indicated Resident #26 should have gotten the Albuterol nebulizer treatments three times per day since she was admitted. She indicated she did not know why the medication had been changed to a PRN order. She indicated she could not locate a physician's order to support why the nebulizer had been changed from a scheduled medication to a PRN by the staff. She indicated she understood the concern related to the medication error. 3.1-25(b)(9) 3.1-48(c)(2)	F 333	**quality assurance program will be put into place?** • A "MAR/TAR Flow sheet" CQI tool will be utilized three times per week for one month then weekly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011.	
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility	F 406	**F406 Provide/Obtain Specialized Rehab Services** If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 63 must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident with physician orders for occupational therapy was provided occupational therapy intervention. This affected 1 of 24 residents reviewed for specialized rehabilitation services in the sample of 24. (Resident # 96) Findings include: The clinical record for Resident # 96 was reviewed on 1/25/11 at 10:15 A.M. Diagnoses for the resident included, but were not limited to, quadriplegia with spasticity. An "Interdisciplinary Progress Notes" form, dated 11/8/10, and signed by a physician, indicated, "... Needs UE (upper extremity) strengthening. See OT (occupational therapy) order..." A physician's telephone order, dated 11/8/10, indicated, "...OT: UE strengthening functional exercises..." There was no documentation in the clinical record to indicate the resident received occupational therapy services related to the physician's order on 11/8/10. During an interview with the Therapy Manager, on 1/26/11 at 8:45 A.M., she indicated she was not	F 406	mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource from a provider of specialized rehabilitative services. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #96 was evaluated by occupational therapy, but was deemed that no skilled therapy services were needed at that time. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents who have physician orders for therapy evaluation or have a change of condition, have the potential to be affected by the alleged deficient practice.	

- Therapists have been re-educated by the Regional Rehabilitation Manager on screen procedure and evaluation without treatment procedure, by March 4, 2011.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

- Therapy screens to be completed upon admission/readmission and no less than quarterly on all residents.
- Therapy screens to be completed on any resident who is referred by Interdisciplinary Team.
- Admissions and readmissions will be communicated by nursing to therapy utilizing the nursing to therapy communication form.
- Residents with therapy orders will be evaluated by skilled discipline. If resident is evaluated per physicians order, and no treatment is indicated this will be communicated to nursing via

communication form following evaluation for feedback to physician.

- A copy of this form will be submitted to Executive Director / Director of Nursing Service for review.
- Executive Director/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- Interdisciplinary Team will review residents during the morning meeting for decline in Activities of Daily Living utilizing the MDS process.
- Clinical Record Audit Tool will be completed upon admission and readmission.
- The CQI committee will review the data gathered and an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 64 aware of the 11/8/10 physician's order for occupational therapy. She indicated the resident was currently on restorative nursing, and at the time of the 11/8/10 order, the resident had just finished occupational therapy. She indicated the resident was seen at that time related to new splints. She indicated the resident would not have been appropriate for occupational therapy at that time, and no screening or evaluation was completed as a result of the physician's order on 11/8/10. During an interview with the Director of Nursing on 1/28/11 at 4:15 P.M., she indicated the therapy staff should have screened the resident after the physician's order on 11/8/10. A current facility policy, revised 12/09, provided by the Executive Director on 1/31/11 at 8:40 A.M., titled "Screening", indicated, "...It is our policy to ensure that all resident who may potentially need rehabilitation services are reviewed, identified and referred on a regular basis...." 3.1-23(a)(1)	F 406	disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	**F431 Drug Records, Label/store Drugs & Biologicals** It is the practice of this facility to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 65 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 staff members disposed of and signed off on the destruction of narcotic medications, and failed to ensure a policy was in place related to the destruction of narcotic medications. This deficient practice effected 1 of 24 residents reviewed for medication destruction in a sample of 24. (Resident # 149) Findings include: The closed record of Resident # 149 was reviewed on 1/28/11 at 4:35 p.m.	F 431	maintained and periodically reconciled. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #149 no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents who utilize controlled drugs have the potential to be affected by the alleged deficient practice. • Licensed Nurses were re-educated on the narcotic destruction, by the Staff Development Coordinator/designee, by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	

- When controlled medications are discontinued it must be pulled from the medication cart and destroyed by two nurses.
- Controlled Schedule II medications will be destroyed by flushing down a toilet or hopper.
- Two nurses must witness the destruction of narcotic medication and sign off the "Destruction of Narcotics" form; to include the number of drugs destroyed and date they were destroyed.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- A "Medication Storage Review" CQI tool will be utilized two times per week for one month then weekly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 66 A Medication Destruction Sheet, dated 1/3/11, indicated a nurse destroyed 30 mL (milliliters) of "Morphine Sulfate (controlled substance- narcotic pain medication) 20 mg (milligrams) / mL #30 (30 mL)." Documentation was lacking to indicate the medication destruction was witnessed by another nurse. During an interview with Assistant Director of Nursing on 1/27/11 at 12:15 p.m., she indicated there was no specific policy related to the destruction of medications. During an interview with LPN # 8 on 1/28/11 at 5:15 p.m., he indicated there must be two nurses to witness and sign off on the destruction of narcotic medications. During an interview with LPN # 30 on 1/28/11 at 5:18 p.m., she indicated there must be two nurses to witness and sign off on the destruction of narcotic medications. During an interview with the Director of Nursing on 1/28/11 at 5:20 p.m., she indicated there must be two nurses to witness and sign off on the destruction of narcotic medications. She indicated she could not locate any other documentation related to two nurses having destroyed the Morphine. She indicated there was no specific policy related to the destruction of medications. She indicated it was standard practice for two nurses to destroy narcotic medications.	F 431	times two months and then quarterly thereafter. • The CQI committee will review the data gathered and if threshold is not achieved, an action plan may be developed. • Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	
F 441 SS=E	3.1-25(o) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	**F441 Infection Control, Prevent Spread, Linens**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 67 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	It is the practice of this facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #65 and #115 receives blood sugar checks utilizing proper infection control technique. • Resident #88, #96 and #148 receives wound care utilizing proper infection control technique. • Resident #89 receives eye medication utilizing proper infection control technique. • Resident # 132 no longer resides at facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 68 Based on observation, interview, and record review the facility failed to ensure staff followed infection control procedures related to handwashing, scissor and blood glucose machine disinfection, and cross contamination during a wound dressing change. This deficient practice effected 5 of 24 residents in a sample of 24; 2 of 7 residents in a supplemental sample 7 reviewed for appropriate infection control measures. (Residents # 65, #88, #89, #96, #115, #132 and #148) This involved 7 staff members. (CNA # 5, LPN # 2, LPN # 6, LPN # 8, LPN #15, LPN #11, and RN #9) Findings include: 1. During an observation of the medication pass on 1/24/11 at 4:10 p.m., with LPN #15 and the Director of Nursing (DoN) the following was observed: 1a. The LPN began to do a blood sugar check on Resident #115 The LPN assembled the glucose machine, the lancettes, put gloves on her hands, and entered the room. The LPN checked the resident's glucose level. The LPN removed her gloves, threw them into the trash, and left the room. The LPN failed to wash her hands after removing her gloves. The LPN proceeded to the medication cart, laid the glucose machine on the medication cart, and began to get into the medication cart to draw up the resident's insulin. The LPN returned to the cart and drew up the required insulin for Resident #115. The LPN failed to put a barrier between the glucose machine and the medication cart and failed to cleanse her hands before preparing insulin for the resident. The LPN entered the	F 441	• Residents who reside in the facility have the potential to be affected by the alleged deficient practice. • Licensed Nurses were re-educated on correct cleansing of glucometers, infection control practices with wound care and medication administration, by the Staff Development Coordinator/designee, by March 4, 2011. • Nursing staff were re-educated on infection control while passing ice water by the Staff Development Coordinator/designee by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Upon hire and no less than annually a skills validation will be completed on licensed nurses in regards to infection control (glucometer disinfection, eye drops and wound treatments) by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 69 resident's room and administered the insulin into the resident's stomach. The LPN washed her hands and went back to the medication cart. The LPN got an alcohol pad out of the medication cart, picked up the glucose machine, and cleaned the machine. The LPN laid the machine on the medication cart. The LPN identified the next resident to be checked and began to assemble the items needed. The LPN was stopped by the DoN at that time. During an interview at the time of the observation, the LPN indicated using alcohol on the glucose machine was not appropriate. She indicated "We have wipes we are supposed to use, but I don't have any in my cart." She checked her medication cart for the germicidal wipes to make sure. The medication cart did not contain a tub of germicidal wipes. The DoN then instructed the LPN the use of alcohol was inappropriate and to go and retrieve a tub of germicidal wipes from supply. The LPN returned with the germicidal wipes, cleansed the blood glucose machine, and laid it on the medication cart. The LPN failed to place a barrier between the glucose machine and the medication cart. During an interview with the LPN at the time of the observation she indicated she should have placed a Kleenex or paper towel between the machine and the medication cart. The LPN was stopped by the DoN and instructed to clean the machine again and place a Kleenex or paper towel between the machine and the medication cart. The LPN cleaned the blood glucose machine again, placed a Kleenex on the	F 441	Staff Development Coordinator/designee. • Skills validations are completed 3 times a week for 1 month to ensure competency with infection control on medication pass and treatments by Staff Development Coordinator/designee. • Nurse Managers will complete two ice water pass skills validation on nursing staff per week for one month to ensure competency with infection control while passing ice water. • DNS/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • An "Infection Control" CQI tool will be utilized two times per week for one month then weekly times two months and then quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 70 medication cart and laid the machine on the Kleenex. The LPN placed gloves on her hands, and entered the next residents room to check the blood glucose. The LPN failed to sanitize her hands after handling the soiled blood glucose machine, and before entering the next resident's room to perform care. During an interview with the DoN immediately following the observation, she indicated the LPN did not use appropriate infection control techniques during the blood sugar/insulin administration. She indicated the LPN should have used a germicidal cleaner to cleanse the machine. She indicated the use of alcohol was inappropriate. She indicated the LPN should have used a barrier between the machine and the medication cart after it was appropriately cleaned. She indicated the LPN should have sanitized her hands before entering the room, after removing her gloves, before drawing up the insulin, and after handling the soiled glucose machine. A policy and procedure, dated 1/2010, titled "Procedure for calibrating and cleaning glucose meter" provided by the Executive Director on 1/25/11 at 8:50 a.m., identified as current indicated "...Purpose: To prevent cross contamination during resident use...Frequency: The blood glucose meter is to be disinfected prior to the meter being used, between each resident, and before returning to the secured cart...Procedure: wash hands...place paper towel and/or disposable...pad on hard surface. Don clean gloves. Dispense approved germicidal pre-moistened disposable wipe. Wipe entire exterior surface of the blood glucose meter with pre-moistened wipe...Dispose of the used towelette into the trash...Doff (remove gloves).	F 441	• The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed. • Noncompliance with facility procedure may result in employee education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 71 Wash hands...." 2. During an observation of the medication pass on 1/24/11 at 4:22 p.m., with LPN #15 and the Director of Nursing (DoN) the following was observed: The LPN began to perform a blood sugar check on Resident #65. The LPN assembled the glucose machine, the lancettes, put gloves on her hands, and entered the room. The LPN failed to wash her hands prior to entering the resident's room after handling a contaminated blood glucose machine. The LPN checked the resident's glucose level. The LPN removed her gloves, threw them into the trash, and left the room. The LPN failed to wash her hands after removing her gloves. The LPN proceeded to the med cart, laid the glucose machine on the med cart, and began to get into the medication cart to draw up the resident's insulin. The LPN drew up the required insulin for Resident #65. The LPN failed to cleanse her hands before preparing insulin for the resident. The LPN entered the resident's room and administered the insulin into the resident's stomach. The LPN washed her hands and went back to the medication cart. During an interview with the LPN immediately following the observation, she indicated she should have sanitized her hands after removing her gloves. During an interview with the DoN immediately following the observation, she indicated the LPN should have washed her hands before going into the room, and after taking off her gloves. She	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 72 indicated she understood the inappropriate infection control concerns. 3. During an medication administration observation on 1/25/11 at 8:40 a.m., with RN # 9 and the Director of Nursing (DoN) the following was observed: The RN #9 instilled eye drops to Resident #89. The RN had gloves on his hands during the administration of the eye drops. After instilling the eye drops to the resident, the RN removed his gloves and left the room. The RN returned to the medication cart and began to prepare the resident's g-tube medications. The DoN stopped the RN and told him to go back into the room and wash his hands. During an interview with the RN immediately following the observation, he indicated he should have washed his hands after he removed his gloves. During an interview with the DoN following the observation, she indicated the RN should have washed his hands after removing his gloves. 4. During an observation on 1/25/11 at 10:40 a.m., with LPN # 11 and the Director of Nursing (DoN) the following was observed: The LPN assembled the supplies needed to change Resident #88's dressing on his heel. She entered the resident's room, placed a towel over the bedside table for a barrier. The LPN placed the supplies on the towel . The LPN removed a pair of scissors from her pocket and laid them on the towel with the other supplies. The LPN used the scissors to remove the old gauze dressing,	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 73	F 441		

and proceeded with the dressing change. After the dressing was removed and the wound was cleansed, the LPN used the same scissors to cut the clean gauze after re-wrapping the resident's foot. At no time during the observation did the LPN cleanse her scissors.

During an interview immediately following the observation, the LPN indicated her scissors were clean and had not been used yet. She indicated she should have cleaned them before she used them and during the dressing change.

During an interview with the DoN immediately following the observation, she indicated the LPN should have made sure the scissors were cleansed before using them during the dressing change.

5. During observation of a dressing change, on 1/25/11 at 2:55 P.M., for Resident # 96, with LPN # 8 and the Director of Nursing present, the following was observed:

LPN # 8 cleansed the resident's wound. LPN # 8 wet a piece of guaze with normal saline and patted the edges of the wound, and then patted the inside of the wound with the same piece of guaze. LPN # 8 cut a piece of silver alginate and placed it on the outside of an empty package. LPN # 8 then took the silver alginate from the outside of the package and placed it directly on the resident's open wound.

During an interview with the Director of Nursing immediately following the above observation, she indicated her concern with the observation was the technique used to cleanse the resident's wound. She further indicated LPN # 8 should have had all of his supplies ready, and not placed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 74 the alginate on the outside of the opened package. 6. During observation of a dressing change, on 1/26/11 at 9:50 A.M., for Resident # 132, with LPN # 6 and the Director of Nursing, the following was observed: The resident had an open area at the site of the right great toe amputation. At that time, treatment was applied to the resident's toe and the resident's wound was dressed according to the physician's orders. LPN # 6 wore gloves throughout the dressing change, but did not apply any additional personal protective equipment. During observation on 1/27/11 at 10:15 A.M., there was no isolation sign or isolation cart present in the resident's room. The clinical record for Resident # 132 was reviewed on 1/26/11 at 3:55 P.M. Diagnoses for the resident included, but were not limited to, osteomyelitis of the right great toe with amputation. A nursing note, dated 1/14/11 at 3:30 P.M., indicated, "Res (resident) returned from appt. (appointment) N.O. (new order) for contact isolation d/t (due to) MRSA (methicillin resistant staphylococcus aureus) to R (right) foot...." A physician's order, dated 1/14/11, indicated the resident was to be in contact isolation due to MRSA in the right foot. During an interview with the Director of Nursing on 1/27/11 at 10:50 A.M., she indicated if a wound was draining, then staff would be expected	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 75 to wear a gown and gloves to prevent contamination. She indicated there should be a stop sign on the door to alert visitors. A current facility policy, dated 1/09, provided by the Corporate Nurse Consultant on 2/4/11 at 12:30 P.M., titled "Contact Precautions" indicated, "...Contact Precautions are indicated to prevent and control nosocomial transmission of infection with any of the following: ... Staphylococcus aureus resistant to Methicillin/oxacillin if present in a site that has copious secretions not contained, i.e., draining wound...Precaution Sign: Post a sign at the resident's door to advise the visitors to consult with the Charge Nurse before entering the room...." 7. During an observation on 01/25/2011 at 9:45 a.m., CNA (Certified Nursing Assistant) # 5 was observed passing ice water to residents on the 2nd floor East hall. The CNA entered three different resident rooms without sanitizing or washing her hands between passing ice water to each resident. The CNA touched multiple surfaces including the residents' bedside tables, individual water pitchers, bathroom doors, bathroom faucets and entry doors to the resident's rooms. The CNA assisted Resident # 148 with a drink by holding the water glass and straw while the resident drank from the straw. During an interview on 01/25/2011 at 9:50 a.m., CNA # 5 indicated she did not sanitize or wash her hands. She indicated she should have washed her hands between resident rooms. During an interview on 01/25/2010 at 10 a.m., RN # 3 and the ADoN (Assistant Director of Nursing) indicated the CNA should have washed her hands between passing water to each resident.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 76	F 441		

During an interview on 01/25/2010 at 10:20 a.m., the DoN (Director of Nursing) indicated she would expect hand washing to occur before the CNA assisted the resident with her drinking glass.

A facility policy, dated 02/2010 and titled, "Passing Fresh Ice Water" was provided by the DoN. The policy indicated, "Wash hands...Offer the resident a drink of fresh water if resident is present. Repeat procedure until all resident's have been provided with fresh ice water. Wash hands...."

8. The clinical record for Resident # 148 was reviewed on 01/27/2011 at 10:45 a.m.

Diagnoses included, but were not limited to, weakness, renal (kidney) failure, COPD (chronic obstructive pulmonary disease), pacemaker, amenia (decrease in the number of red blood cells), dermatitis (inflammation of the skin), and cellulitis (skin infection).

During an observation on 01/25/2011 at 11:05 a.m., LPN # 2 provided wound care to Resident # 148's bilateral buttocks. The ADoN (Assistant Director of Nursing) observed the LPN perform the wound care. LPN # 2 placed normal saline ampules that had been used to cleanse the resident's wound into a plastic bag containing soiled dressings. The LPN touched the inside of the plastic bag with her gloved hand, then resumed wound care without washing her hands and applying new gloves.

During an interview on 01/25/2011 at 11:30 a.m., the ADoN indicated the LPN should not have touched the inside of the plastic bag with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 77 gloved hands and then resumed wound care without washing her hands and applying new gloves. 3.1-18(l)	F 441		
F 502 SS=E	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure labs were obtained as ordered by the physician for 3 of 24 residents reviewed for completed laboratory services in a sample of 24. (Residents # 26, #88, and #96). Findings include: 1. Resident # 26's record was reviewed on 1/28/11 at 10:00 a.m. Diagnoses for Resident #26 included, but were not limited to, CVA (stroke), atrial fibrillation, cardiac arrhythmias, hypertension, CAD (coronary artery disease), and a history of congestive heart failure. Medication Administration Records, dated January 2011, indicated the physician orders included the medication warfarin (Coumadin), an anticoagulant medication. A physician's order, dated 1/10/11, indicated the facility was to draw a PT/INR laboratory test on 1/17/11. Documentation was lacking to indicate	F 502	**F502 Provide/Obtain Laboratory SVC-Quality/Timely** It is the practice of this facility to provide or obtain laboratory services to meet the needs of its residents in a quality and timely manner. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #26 had a PT/INR drawn on 1/18/11 with physician notification and medication currently being monitored by the Coumadin Clinic. • Resident #88 had labs drawn, physician was notified. • Resident #96 physician was notified and order obtained for labs at a later date. **How will you identify other residents having the potential to be affected by the same deficient**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 78 the lab had been drawn as ordered by the physician. During an interview with the Director of Nursing (DoN) on 1/28/11 at 3:10 p.m., she indicated the lab had not been done as ordered by the physician. 2. Resident #88's record was reviewed on 1/25/10 at 3:25 p.m. Diagnoses for Resident #88 included, but were not limited to, anemia, diabetes mellitus, atrial fibrillation, coronary artery disease, and malnutrition. A physician's order, dated 1/8/11 at 9 p.m., indicated "...CBC (complete blood count) on 1/8/11...CMP (comprehensive metabolic panel) on 1/8/11...." Documentation was lacking to indicate the lab had been drawn as ordered by the physician. During an interview with LPN #11 on 1/26/11 at 10:30 a.m., she indicated she could not locate documentation related the lab having been done as ordered by the physician. LPN #11 indicated she spoke with someone from the lab and the CBC and CMP had not been completed. During an interview with the DoN on 1/26/11 at 11:40 a.m., she indicated she could not locate documentation related to the labs having been done as ordered by the physician. 3. The clinical record for Resident # 96 was reviewed on 1/25/11 at 10:15 A.M. Diagnoses for the resident included, but were not limited to, deep vein thrombosis. The physician's order summary for 1/11 indicated	F 502	**practice and what corrective action will be taken?** • Residents who require lab testing have the potential to be affected by the alleged deficient practice. • Licensed staff and nurse managers have been re-educated on lab tracking by the DNS/designee by March 4, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Lab orders are reviewed in the morning clinical meeting (Monday – Friday). • Lab binders will be brought to the morning clinical meeting (Monday – Friday) to review for the completion of labs. • Notify lab through requisition. • When lab results return notify physician for clinical course and notify responsible party of new orders. • Physician orders will be reviewed in the morning meeting (Monday thru Friday)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 79 the resident had a current physician's order for Coumadin (a medication to increase bleeding time) 5 milligrams by mouth on Tuesday, Thursday, and Saturday and Coumadin 7.5 milligrams by mouth on Monday, Wednesday, Friday, and Sunday. A physician's order, dated 11/24/10, indicated, "Hold coumadin today 11/24/10 resume current dose on 11/25/10 recheck PT/INR (a laboratory test to measure bleeding times) in 2 weeks 12/8/10...." There was no laboratory result in the clinical record to indicate the PT/INR was drawn on 12/8/10 as ordered by the physician. A laboratory requisition form, dated 12/6/10, had a hand written note which indicated, "cancel PT/INR for 12/8/10..." There was no physician's order in the clinical record to cancel the 12/8/10 PT/INR. During an interview with the Director of Nursing on 2/4/11 at 10:30 A.M., she indicated there was not a physician's order to discontinue the lab on 12/8/10 and it should have been drawn at that time. She indicated it was an error. 4. A policy and procedure dated July 08, titled "Guidelines for lab tracking" provided by the DoN on 1/26/11 at 11:30 a.m., identified as current indicated "...set up a lab tracking binder with a list for...daily labs, weekly labs, monthly labs...review MD orders and place in tracking binder at time order reviewed. When ordering lab-fax order to alb, then place it in separate binder at nurses' station. When lab comes to draw lab-nurse to	F 502	by Nurse Management to ensure lab orders are tracked and care plans are updated as needed. • The lab order is placed on the lab tracking form and the charge nurse/unit manager is responsible for follow-up. • The lab tracking form will be reviewed in the morning meeting to ensure follow up with lab test is completed and orders obtained for treatment as needed. • DNS/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • A "Lab Tracking" CQI tool will be utilized 2 times a week for 1 month then weekly for 2 months and then quarterly. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 80 sign lab slip upon arrival and upon departure-put copy of form with nurses signature in the lab draw binder...Monthly- review lab tracking binder at the time of completion of the rewrites to ensure lab orders and MD orders match...." 3.1-49(a)	F 502	• Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination. **Compliance date:** March 4, 2011	
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure prompt physician notification of an abnormal lab for 1 of 24 residents reviewed for abnormal labs in a sample of 24 residents (Resident # 19). Findings include: The record of Resident # 19 was reviewed on 01/26/2011 at 10:45 a.m. Diagnoses for Resident # 19 included, but were not limited to, CHF (congestive heart failure), diabetes type 2, anemia (decreased number of red blood cells), altered mental status, cardiomyopathy (deterioration of the function of the heart muscle), and acute renal (kidney) failure. A laboratory report, dated 01/12/2011, indicated abnormal lab values including, but not limited to, Hemoglobin (a protein in red blood cells that carries oxygen) low at 9.6 (normal was 14-18),	F 505	**F505 Promptly Notify Physician of Lab Results** It is the practice of this facility to promptly notify the attending physician of the findings. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #19 receives medications per PEG tube as per physician orders. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • Residents who require lab testing have the potential to	

be affected by the alleged deficient practice.

- Licensed staff and nurse managers have been re-educated on lab tracking by the DNS/designee by March 4, 2011.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

- Lab orders will be reviewed in morning meeting (Monday thru Friday) to ensure that labs are being ordered and results reported timely to the physician with treatment orders obtained as needed.
- Physician orders will be reviewed in the morning meeting (Monday thru Friday) by Nurse Management to ensure lab orders are tracked and care plans are updated as needed.
- The lab order is placed on the lab tracking form and the charge nurse/unit manager is responsible for follow-up.
- The lab tracking form will be reviewed in the morning

meeting to ensure follow up with lab test is completed and orders obtained for treatment as needed.

- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?

- A "Lab Tracking" CQI tool will be utilized 2 times a week for 1 month then weekly for 2 months and then quarterly.

- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 505	Continued From page 81 Hematocrit (measures the percentage of the volume of whole blood that is made up of red blood cells) low at 28.6 (normal was 40-54). A physician's order, dated 01/21/2011, indicated, " Ferrous Sulf (Sulfate) 220/5 ml (milliliter) elx (elixir) 7.4 ml (325 mg (milligram) per peg tube tid (three times daily)." During an interview on 01/26/2011 at 2:30 p.m., the DoN indicated the lab was faxed to the physician on 01/12/2011 but was unsure if the fax was reviewed by the physician prior to the date the order was written for Ferrous Sulfate. She indicated the facility should have pursued a more timely follow up with the physician. 3.1-49(f)(2)	F 505		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 514	**F514 Clinical Records** It is the practice of this provider to maintain clinical records on each resident in accordance with accepted professional standards and practice that are complete; accurately documented; readily accessible; and systematically organized. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** • Resident #88 code status was reviewed with clinical record	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 82 failed to ensure clinical records were accurate related to code status. This deficient practice effected 1 of 24 residents reviewed for complete and accurate clinical records in a total sample of 24. (Residents #88) Findings Include: The clinical record for Resident #88 was reviewed on 1/25/11 at 3:25 p.m. Diagnoses for the resident included, but were not limited to, hypertension, coronary artery disease, atrial fibrillation, anemia, malnutrition, and depression. Resident #88 was admitted to the facility on 12/6/10. A "patient transfer record" from the hospital, dated 12/6/10, indicated, "...Resuscitation status: no code blue..." A "physician's order" form from the hospital, dated 12/6/10, indicated "...code status: no code blue...." The physician's order summary for 12/10, indicated the resident was a "...no code blue...." The physician's order summary for 1/11, did not identify the resident's code status. A social service progress note, dated 12/16/10, indicated "...Res (resident) is a full code...." A care plan. dated 12/21/2010, indicated "...resident has choosen [sic] to have life sustaining measures...goal...resident will received CPR [cardiopulmonary resuscitation] and ambulance will be called...."	F 514	updated to reflect current status. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** • All residents who reside in the facility have the potential to be affected by the alleged deficient practice. • Resident's clinical records were reviewed to ensure appropriate documentation of code status. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** • Licensed Nurses were re-educated on the policy on advances directives, by March 4, 2011. • Upon admission and with significant changes advance directives are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	02/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 83 During an interview with LPN #11 on 1/26/11 at 10:30 a.m., she indicated the code status for Resident # 88 was not clear based on the documentation in the clinical record. She indicated the resident was supposed to be a full code. During an interview with the Director of Nursing on 1/26/11 at 10:35 a.m., she indicated she was not sure why there was conflicting documentation in the clinical record. She indicated the resident was a full code. 3.1-50(a)(2)	F 514	reviewed with resident and responsible party. • DNR forms will be signed and dated and will be placed in the residents charts. The NO CODE order will be indicated on residents' medication record. • CODE STATUS will be reviewed with resident and or responsible party during the quarterly care plan conference and / or during significant change in condition. • If resident or responsible party decides to change the code status the physician will be contacted and a new order will be obtained. • DNS/designee is responsible to ensure compliance with facility procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** • An "Advanced Directives" CQI tool will utilized weekly times four and then monthly	

times 2 and then semi annually thereafter.

- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011